NOTE

This Microfiche meets the quality requirements of the American National Standard for Microfiche of Documents (ANSI PH5.9-1975). However, because of imperfections in the document from which it was made, it contains images that are illegible or difficult to read. The source document for this microfiche is the best copy that could be obtained prior to filming.

CIS

Congressional Information Service, Inc.
Washington, D.C.

FEDERAL DRUG STRATEGY—1983

HEARINGS

BEFORE THE

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL HOUSE OF REPRESENTATIVES

NINETY-EIGHTH CONGRESS

FIRST SESSION

NOVEMBER 1 AND 2, 1983

Printed for the use of the
Select Committee on Narcotics Abuse and Control

SCNAC-98-1-6

U.S. GOVERNMENT PRINTING OFFICE
35-288 O
WASHINGTON : 1984

H961-17.

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

CHARLES B. RANGEL, New York, *Chairman*

PETER W. RODINO, JR., New Jersey
FORTNEY H. (PETE) STARK, California
JAMES H. SCHEUER, New York
CARDISS COLLINS, Illinois
DANIEL K. AKAKA, Hawaii
FRANK J. GUARINI, New Jersey
ROBERT T. MATSUI, California
DANTE B. FASCELL, Florida
WALTER E. FAUNTROY, District of Columbia
WILLIAM J. HUGHES, New Jersey
SAM B. HALL, JR., Texas
MEL LEVINE, California
SOLOMON P. ORTIZ, Texas
LAWRENCE J. SMITH, Florida
EDOLPHUS "ED" TOWNS, New York

BENJAMIN A. GILMAN, New York
LAWRENCE COUGHLIN, Pennsylvania
E. CLAY SHAW, JR., Florida
MICHAEL G. OXLEY, Ohio
JOEL PRITCHARD, Washington
STAN PARRIS, Virginia
GENE CHAPPIE, California
DUNCAN HUNTER, California
TOM LEWIS, Florida

COMMITTEE STAFF

JOHN T. CUSACK, *Chief of Staff*
RICHARD B. LOWE III, *Chief Counsel*
ELLIOTT A. BROWN, *Minority Staff Director*

CONTENTS

TUESDAY, NOVEMBER 1, 1983

Page

Testimony of Carlton E. Turner, Special Assistant to the President for Drug Abuse Policy, Director, Drug Abuse Policy Office, accompanied by Daniel F. Leonard, Deputy Director, Drug Abuse Policy Office, Office of Policy Development 4
Submission for the record: Additional questions for Dr. Carlton E. Turner with Dr. Turner's response 43
Prepared statements:
  Opening statement by Chairman Charles B. Rangel 49
  Opening statement by Congressman Benjamin A. Gilman 49
  Carlton E. Turner, Ph. D 50

WEDNESDAY, NOVEMBER 2, 1983

Testimony of Hon. Charles E. Bennett, a Representative in Congress from the State of Florida 56
Testimony of Dr. William Pollin, Director, National Institute on Drug Abuse, Department of Health and Human Services 61
Testimony of Thomas W. Pauken, Director, ACTION 77
Testimony of Kenneth Eaton, administrator, Michigan Office of Substance Abuse Services, chairman, Legislative Committee, National Association of State Alcohol and Drug Abuse Directors 93
Testimony of Paul E. Robinson, executive secretary, Coordinating Council on Drug Abuse, City of Boston, immediate past chairperson, National Association for City Drug and Alcohol Coordination 106
Testimony of Dr. Nicholas L. Piccone, executive director, Coordinating Office for Drug and Alcohol Abuse Programs, Philadelphia 109
Testimony of Dr. Alyce C. Gullattee, director/administrator, Institute of Substance Abuse and Addiction, Howard University Hospital, Washington, D.C.; Former Administrator, Alcohol and Drug Abuse Services Administration, Washington, D.C 113
Submissions for the record:
  Additional questions for Thomas W. Pauken with response from ACTION 128
  Additional questions for Dr. William Pollin with Dr. Pollin's response 220
  Additional information furnished by Nicholas L. Piccone 278
  Presentation of Arthur Jaffe, president, New York State Association of Substance Abuse Programs 295
  Testimony by Mark W. Parrino, chairman, New York State Committee of Methadone Programs Administrators, in support of Arthur Jaffe's presentation 374
  Statement by Richard Pruss, president, Therapeutic Communities of America, in Support of Arthur Jaffe's presentation 377
Prepared statements:
  Opening statement by Chairman Charles B. Rangel 299
  William Pollin, M.D 303
  Thomas Pauken 325
  Thomas Kirkpatrick, Jr. and Kenneth Eaton (joint statement) 337
  Paul E. Robinson 363
  Nicholas L. Piccone 380
  Joyce D. Nalepka, senior vice president, National Federation of Parents for Drug-Free Youth 393
  Father John McVernon, executive vice president, National Association on Drug Abuse Problems, Inc 402

FEDERAL DRUG STRATEGY—1983

TUESDAY, NOVEMBER 1, 1983

House of Representatives,
Select Committee on Narcotics Abuse and Control,
Washington, D.C.

The select committee met, pursuant to call, at 10 a.m., in room 2226, Rayburn House Office Building, Hon. Charles B. Rangel (chairman of the select committee) presiding.

Present: Representatives Charles B. Rangel, Frank J. Guarini, Sam B. Hall, Jr., Solomon P. Ortiz, Edolphus "Ed" Towns, Benjamin A. Gilman, Lawrence Coughlin, Michael G. Oxley, Gene Chappie, Duncan Hunter, and Tom Lewis.

Staff present: John T. Cusack, chief of staff; Richard B. Lowe III, chief counsel; George R. Gilbert, counsel; Elliott A. Brown, minority staff director; and Robert Pfeifle, press officer.

Mr. Rangel. Good morning. The select committee will come to order.

This morning we will continue our review of the administration's drug policies. We are pleased to have with us Dr. Carlton Turner, who is the President's Special Assistant for Drug Abuse Policy, who will outline the administration's 1982 Federal strategy for the prevention of drug abuse and drug trafficking and discuss the White House role in the implementation of this strategy.

For the past several months, this committee has conducted an extensive investigation into the drug problems confronting our country, through public hearings, meetings with Government and private officials, both here and abroad, and conducting onsite inspections of narcotics-growing areas. We have attempted to look at all aspects of the problem.

Heroin continues, however, to flow into the northeast region of the country. There are indicators that heroin abuse has jumped dramatically in New York and other northeast cities. Increased heroin activities are not confined to this area, however, because Detroit, Los Angeles, San Antonio, and other cities are now reporting sharp increases in heroin abuse and trafficking activities.

The availability of cocaine is now greater than ever before, and there is a glut on the market, which is driving the cocaine prices downward.

Treatment programs are operating at 100 percent capacity. Demands for their services are fueled by the readily available supply of illicit drugs. As an aside, this morning I have been advised that there is a 1,500-person waiting list in the State of New York for people who have volunteered for treatment, but there are no spaces for them. Despite the increasing need for treatment and prevention, the block grants have been substantially cut and local and State officials have been unable to fund vitally needed programs.

State and local criminal justice systems—police, courts, and prisons—are staggering under the heavy burden of drug-related crime and in many areas arrests do not take place because of the inability of the law enforcement to prosecute these crimes.

Federal law enforcement officials who recently testified before this committee in south Florida conceded that the South Florida Task Force on Crime is not achieving appreciable reductions in the flow of illicit drugs through that region of the country. We were very surprised to find that there had not been any meetings at all between local law enforcement officials and the Federal task force.

Illicit domestic marijuana production is now a major and growing industry. This committee has been to California to see the sophistication that has been used in the cultivation of marijuana and to see that it is now becoming a major industry in certain parts of the United States.

In Colombia, Peru, Bolivia, and Jamaica, where the select committee visited in August, illicit cultivation of coca and marijuana is out of control. Corruption seems to permeate some of these governments. In Bolivia we had officials, drug traffickers, elected to public office. In Jamaica, cultivation was taking place on government property. Illicit air strips were on government property. Some of these countries receive Federal assistance, as in the case of Jamaica, one of the prime beneficiaries of the Caribbean Basin Initiative.

In short, it appeared from our meetings and hearings here and abroad that we are losing this battle against drug abuse. Yet, we do have to recognize that the administration has declared an all-out war where we have seen publicity, both on television and in the printed media, indicating our Government's concern.

Because Dr. Turner is in charge of this strategy, we ask you to come today to share with us what that strategy is, how is it working, and what the Congress can do to be supportive of your effort.

I would like to point out that throughout hearings and trips we have not conducted this committee in a partisan way. Republicans and Democrats have sought to serve on this committee in an effort to serve their constituents, as well as the Nation, in trying to bring some answers to this very serious epidemic we are facing.

Having said that, Mr. Gilman?

Mr. **Gilman**. Thank you, Mr. Chairman.

I am certainly pleased to join with you and our colleagues this morning in welcoming Dr. Turner as we continue to review our Federal drug strategy. We have been involved in an ongoing review of this strategy for some time, and today I am pleased that we will be concentrating on some of the more critical aspects of that strategy, treatment, prevention and research.

No other aspect of our drug policy is more important because despite all of our efforts to halt the supply of illegal drugs, illicit drug availability continues at a totally unacceptable level.

Some of us on the committee have just come from a showing of the cocaine special that had been produced by one of our major TV networks, showing the extensiveness and the impact of cocaine export into our own Nation, how it has affected the country of Colombia, and how it has even penetrated into the political structure of that country; how despite all of our efforts in concentrating our forces in south Florida and while we have helped raise morale in that area, we still have not made a major dent in that flow of trafficking.

We are pleased to have you with us this morning, Dr. Turner. We know of your strong commitment to the success of the Federal strategy, as the President's designated coordinator of our drug abuse efforts. I am certain you will be able to provide us with some of the answers we need to insure that our policies are affected and are targeted in the direction where they can do the most good.

Our select committee is interested in learning from you just how the Federal drug strategy has been developed and what steps you are taking to coordinate the efforts of our Government to halve the demand and the supply of illicit drugs.

Of equal importance, we would also like to know the extensiveness of the Federal Government's efforts in providing funds and technical assistance to the State and local governments in their efforts to combat drug abuse.

The alcohol, drug abuse and mental health block grant has now been in existence for some 2 years. We are interested in learning its effectiveness in meeting the pressing needs of State and local governments.

Dr. Turner, there is no question that the use of marijuana, cocaine, alcohol, and other dangerous substances by our school-age children is a major cause for concern. Parent groups are an important ingredient in any approach to develop a comprehensive, coordinated Federal drug strategy.

However, in my view the Federal Government needs to intensify its efforts to combat drug trafficking and drug abuse if we are to succeed in winning this deadly war. In that regard, we look forward to hearing your testimony. We welcome you before our committee.

Thank you, Mr. Chairman.

Mr. RANGEL. The Chair welcomes the presence of Congressman Hall, Congressman Oxley, Congressman Chappie, and Congressman Ortiz and would welcome any statement at this time from anyone seeking recognition.

Let me thank you, Dr. Turner, for submitting your statement so far in advance, which gave the members, as well as staff, an opportunity to review it. We all expect to be joining with you in a few hours at the White House as the President signs into law National Drug Abuse Week.

You may proceed as you find most comfortable. Your entire statement will be entered into the record. If you care to, you may highlight that and spend most of our time on questions and answers or, if you care to, you may read the full statement, however you feel most comfortable.

On behalf of the full committee and indeed the Congress, we thank you for your presence here this morning.

TESTIMONY OF CARLTON E. TURNER, SPECIAL ASSISTANT TO THE PRESIDENT FOR DRUG ABUSE POLICY, DIRECTOR, DRUG ABUSE POLICY OFFICE, ACCOMPANIED BY DANIEL F. LEONARD, DEPUTY DIRECTOR, DRUG ABUSE POLICY OFFICE, OFFICE OF POLICY DEVELOPMENT

Dr. **Turner**. Mr. Chairman, with your permission I would like to summarize and then open it up for questions and answers.

Mr. **Rangel**. Without objection.

Dr. **Turner**. Mr. Chairman, distinguished members of the Select Committee on Narcotics Abuse and Control, I am pleased to have this opportunity to appear before you today to discuss the health-related aspects of the 1982 Federal Strategy for the Prevention of Drug Abuse and Drug Trafficking.

In March 1981 President Reagan identified drug abuse as "one of the gravest problems facing us" and embarked on a vigorous program to help us as individuals and as a society overcome the problems associated with drug abuse. The 1982 Federal Strategy for Prevention of Drug Abuse and Drug Trafficking, which was released on October 5, 1982, is designed to provide direction to the national effort against drug abuse. The 1982 strategy endorses international initiatives and vigorous law enforcement to reduce the availability of illicit drugs. Simultaneously, major health initiatives are being undertaken to reduce the abuse of drugs, including alcohol, and to prevent drug abuse in future generations of Americans.

The President has assigned a high priority to the drug abuse program and charged two cabinet councils with program responsibilities. I am a Special Assistant to the President and, as indicated by Executive Order 12368, I provide drug abuse policy advice to the President and coordinate and oversee the drug abuse functions of the Federal agencies.

The Cabinet Council on Human Resources is responsible for overseeing the implementation of the health-related aspects of the 1982 Federal strategy, published in October 1982. I chair a working group on drug abuse health issues, under this Cabinet Council. I have established five task forces to assist and report on the implementation of that.

The working group task forces on education and prevention, detoxification and treatment, research, international cooperation, and drug abuse in the Armed Forces have contributed to an implementation status report which will be completed within the next few weeks and furnished to the members of the Cabinet Council on Human Resources.

Participants in the task forces include the Departments of Defense, Education, Health and Human Services, Justice, Labor, State and Transportation. Independent agencies include ACTION, the Office of Science and Technology Policy, the U.S. Information Agency, and the Veterans' Administration.

The consolidated report will summarize the task force efforts and contain recommendations for the consideration of the Cabinet Council. We will use the report as a basic reference in preparing the 1984 strategy in the fight against drug abuse. When the report is completed, I will provide it to the committee, and I will appreciate your counsel.

In discussing the health-related aspects of the drug program today, it is important to recognize that the law enforcement agencies have an important role in preventing drug abuse in the United States.

Our law enforcement agencies are respected members of our communities, have credibility regarding their knowledge of the effects of illegal drugs, and are role models for many of our young people. Therefore, the many thousands of law enforcement officers, Federal, State and local, can and do play a special part in the prevention of drug abuse in this society.

The Drug Enforcement Administration and the U.S. Customs Service are actively pursuing this important prevention role. The Federal Bureau of Investigation and the Office of Juvenile Justice and Delinquency Prevention are also contributing.

We must emphasize, however, that drug abuse is not just a Federal problem. It is a national problem and must be the target of a national program. In the past, it often seemed that blaming the Federal Government was a way in which you solved the problem. Unfortunately, this created a form of denial of individual and community responsibility and provided an excuse for inaction. Fortunately, times have changed.

All across the United States our citizens, community organizations, and businesses have recognized that they can make a difference and are enthusiastically entering the battle against drug and alcohol abuse. Therefore, our national effort is characterized by a high level of commitment, innovation, and cooperation throughout the public and private sectors. Programs have been strengthened, aligned and realigned to address each aspect of the drug abuse problem and to ensure responsiveness to local priorities and needs.

With the cooperation of the Congress and with the other elements of our society, I think we are making a dent.

I will entertain any questions you may have, Mr. Chairman.

[The prepared statement of Dr. Turner appears on p. 50.]

Mr. **Rangel**. Thank you, Dr. Turner.

"Making a dent" doesn't mean a reduction in the availability of cocaine, heroin, or marijuana or reduction in abuse, does it?

Dr. **Turner**. Mr. Chairman, that was probably a poor choice of words for me to use, "making a dent." We want to establish the goal of reducing drug abuse and for a long-term commitment of a generation free of drug abuse, and that means putting all efforts to reduce the flow coming in, as well as changing the drug-taking habits of our people.

Mr. **Rangel**. I assume what you are saying is that notwithstanding this tremendous effort on the part of the Federal Government the situation has worsened and perhaps would be a lot worse if it was not for this effort that this administration has made in this area?

Dr. **Turner**. Mr. Chairman, I can't accept the fact that the situation has worsened. I think if we look at all the surveys we have, we see the use patterns down. There have been five recent surveys—the field report out of California, the high school annual survey, the household survey, the Gallup youth poll survey, the DOD survey—and other surveys which have shown that we have moderated that continuous increase and most parameters show there is a decrease in some categories. I think Dr. Pollin will have the exact data tomorrow when he appears.

Mr. RANGEL. Is it your testimony that the Drug Enforcement Administration would have any statistical data at all to support that there is less cocaine and heroin available to the citizens and that there is less use of heroin and cocaine?

Dr. TURNER. I do not know what the Drug Enforcement Administration's has as of today. I was using the use data figures which the National Institute on Drug Abuse has and the other surveys. I think there are trends that the DEA has talked about, and I think some of the trends we need to look at—the hospital emergency room data related to heroin indicates a decline overall in 1983 compared to 1982 levels. This decline is most pronounced in New York, Philadelphia, and Washington, D.C., according to DEA.

The DEA has also concluded that the national heroin situation for 1983 indicates a relative decline in abuse and availability, particularly in the Northeast, which is primarily supplied by Southwest Asian heroin. I think these are the trends that the DEA has calculated.

Mr. RANGEL. I understand that, doctor. What I want to know is, Is there any statistical data at all issued by the Drug Enforcement Administration that the availability of cocaine or heroin has decreased in the last couple of years?

To put it another way, is there anything to conflict with what this committee has reached a conclusion on, that there has been a dramatic increase in the cocaine that has come into this country to such an extent that it has reduced the price and that abuse and use of cocaine has dramatically increased? Is there any Federal information to contradict the conclusions that this committee has reached as related to cocaine?

Dr. TURNER. The information regarding the cocaine is a moderation of it. There are two things occurring. We have had a continuous increase in drug use, and we have generally accepted in the past that as you have an increase in price, the availability is down. What we are seeing is a moderation in the use of cocaine and, therefore, we have seen a decrease in price because of some decrease in consumption.

Mr. RANGEL. Suppose we were to talk about pounds or kilos so that we would understand. First of all, if there was one person who was in charge of coordinating all of these Federal programs, is it safe to say that you are that person as the special assistant to the President?

Dr. TURNER. I am responsible for coordinating the policy that the President has accepted and put forth. I am not responsible for the operational entities of each agency. Each agency head has that responsibility. But I do coordinate the policy.

Mr. RANGEL. I don't want to ask you questions that concern facts if what you deal with is policy. I can't contradict the administration on policy. I am saying that as we go around the country and the world, we find that most people are saying that there are more drugs available now than ever before.

Policy has nothing to do with that, but you have nothing to do with any of the line action forces that deal with interdiction, prevention, education, rehabilitation. That is not you?

Dr. **Turner**. Yes, sir. I have responsibilities in those areas. We set the policy and we make certain that policy is implemented. So, we have the responsibility of overseeing the implementation of the policy.

I didn't want to insinuate that I take action that would tell the DEA specifically how to commit their agents. My office is a policy-driving mechanism. We have responsibility for policy, and I accept that responsibility.

Mr. **Rangel**. Suppose we were talking about budget and we found in the local and State area that since we have had this Federal strategy or this policy of attempting to encourage communities and local and State governments to assume more of the responsibility that all of us were reporting back that the absence of the Federal presence and the reduction in dollars that are available to take care of these problems on the local level is what we constantly hear about, would that be your responsibility in determining or at least in suggesting the amount of resources that should be made available for law enforcement, treatment, research, and prevention? Would that be you?

Dr. **Turner**. I make recommendations to the President regarding the budgetary concepts of where we ought to go. Those recommendations are made directly to him. They involve law enforcement, they involve international areas and all of those areas, sir.

Mr. **Rangel**. With the exception of the President of the United States, who is responsible to the Nation and the Congress for the enforcement of the strategy which you referred in your testimony?

Dr. **Turner**. Well, the President is the ultimate responsible person. The Vice President has specific responsibilities also. The Attorney General is responsible as the chief law enforcement officer in the United States. In the Cabinet councils, as established by the President, each member of the Cabinet is responsible for their department, under the umbrella of the Cabinet councils.

Mr. **Rangel**. You know that the Congress is moving to get some one person who could respond to us and who would have knowledge of what is and is not happening on the local and international level. They calmly refer to that as a narcotic czar; they call it.

But striking out "czar" and what they call it, do you support the effort of the Congress, the House and the Senate, to have some one person who could report to us about the success or failures, the budget problems of the entire scope of enforcement and drug strategy for the Nation?

Dr. **Turner**. I think the President has made his position very clear on that. He feels that by using the present organization and its strengths, we have a much better situation than we would if we added another layer of bureaucracy.

There are situations where the international issues must be balanced between drugs and other pressing problems. There often are mitigating circumstances, and I support the position that we do not need another level of administrative bureaucracy. I think it would interfere with a system that is working well. I believe the programs we have in place are beginning to work, but I think they need some more time.

Mr. **Rangel**. We are talking, Doctor, not about bureaucracy. We really are talking about accountability. Throughout your testimony you refer to an increased national interest, but throughout our hearings we hear a decrease in Federal resources.

Isn't it true that the Federal strategy is a coordinating effort and an encouragement of local and State efforts, rather than an increase in Federal presence?

Dr. **Turner**. I think we have to look at where the increase in Federal presence is, Congressman. We have an increase in the Federal presence in the South Florida Task Force. We have increased Federal presence internationally now over what we had before. We have an increased Federal presence in the national narcotic border interdiction system. We have increased Federal presence with Customs, with DEA, with the FBI being brought to bear.

We have increased Federal effort, with our military assistance and I thank you for your efforts on their behalf with the exception to posse comitatus. So, I think we have increased Federal efforts in those areas. There is no doubt about that.

Mr. **Rangel**. But budgetarily speaking, while you say that there has been a shift in blaming the Federal Government, I don't think there has been any blame placed. What we do here is that people are not being arrested because of the inability of local law enforcement people even to prosecute.

In California the sheriffs were saying that they couldn't afford to prosecute the cases. We know in the city of New York there is selective enforcement of the law because there is a 1,500 backup in terms of local prosecution.

Each time we talk to any police chief throughout the United States they say, "We don't grow the coca plants. We don't grow the opium. It is not a local problem. It is a Federal problem. If you want to really get a handle on this, we have to deal with the Federal Government."

It just seems to me that while this administration should be lauded for focusing more public attention to the problem, that nobody but nobody is responding to the State and local government's complaint that they have less to work with now than ever before and the problems have increased now more than ever before.

That is a nonpartisan congressional feeling that we get as we go home every weekend. We want to laud you and the administration for chemical people and different strokes and visiting local projects and say that you have done more with the media than any other administration has, but we want to make it abundantly clear that the complaints that we are receiving from local law enforcement and people who are involved in providing some type of treatment have never been as loud as they are today.

Dr. **Turner**. Mr. Chairman, I think if we look at the amount of money in drug law enforcement at the Federal level, we will find that in fiscal year 1980 the budget was approximately $553 million. By 1983 that was nearly doubled.

I think also we would like to address some of the local questions. I just returned from California last weekend and they were very appreciative of your efforts out there in reducing domestic cultivation, but they were also appreciative of the resources that the DEA, Customs, ATF, FBI, and the Coast Guard had contributed to their eradication efforts.

I think we also find other areas where we have good relationships. As I understand it, the principal speakers at the West Palm Beach hearing, the sheriff of Broward County and the representative from the Florida Department of Law Enforcement had nothing but praise for the task force and its efforts.

I know my deputy, Mr. Leonard, has been in consultation with the local law enforcement agencies. With your permission, I think he would like to comment.

Mr. **Rangel**. I am going to have to yield to the other members. I want to point out, though—and I hope that your staff would be able to respond—that the committee has a chart which outlines the Federal expenditures—we will share that with you—for key Federal drug enforcement agencies and programs.

As we go down—FBI, DEA, Customs, Justice, Treasury—we find that there has been a constant level, not even taking into consideration inflation in the amount of funding for these programs, that the FBI, even though they are constantly mentioned, has no line for narcotic enforcement. I would hope that if we can't do it this morning, that we might get more specific as relates to the dollar amounts.

We know about these task forces. We have just left Florida. Again, it is really rough down there. The members from Florida will tell you that everyone appreciates the Federal presence, but no one is talking about less cocaine being available down there.

We had five sheriffs sit before this committee who have said that since the development of this task force, that they have not had any meetings with Federal members of the task force. These were duly elected sheriffs of the five counties in southern Florida.

Again, my time has long expired. I know that Congressman Hall has a meeting with the Judiciary Committee. I apologize to him and yield.

Mr. **Leonard**. Mr. Rangel, let me talk about south Florida for a minute.

Mr. **Rangel**. If you could hold your point because Congressman Hall has to leave. After he inquires, then I certainly will recognize you to respond, Mr. Leonard.

Mr. **Hall**. Thank you, Mr. Chairman. I do have a judiciary meeting that started about 5 minutes ago. I would like to ask one or two questions of Dr. Turner.

We were in New York a few weeks ago on a factfinding mission. We had testimony from the people there that out of 36 schools that had been checked a few days prior to our meeting—high schools, intermediate schools and elementary schools—that out of the 36 schools, only 1 school, Brooklyn 10, I think it was an elementary school, was the only one, in which cocaine or marijuana—I think cocaine—was not being used or sold in the school during the time that the investigation was made.

It appears to me that that is a deplorable situation. Is your organizational setup established in such a way that any type of information or any type of help can be given to these schools to try and stop or curtail the use of narcotics in the school rooms, in the school buildings themselves?

Dr. TURNER. Yes, sir, Mr. Hall. The Department of Education has prepared helpful curriculum which is being used by, I believe, 4,500 schools. The National Institute on Drug Abuse is looking at some prevention strategies that can be used by individual school districts.

The other thing that we have is that there has been a series of documents prepared for distribution to elementary schools across the country. Some have been distributed. Others will be distributed in the coming months.

We have also worked with Weekly Reader that goes into the schools, to help influence curriculum in the schools. We are paying attention to the schools. We think it is very important because we must start at an early age, if we are going to have an effect on drug abuse by our young people.

Mr. HALL. They told us at that meeting that there were 9- and 10-year-olds in those schools, who were pushers, which sounds terribly exaggerated to me. But when the people who are familiar with it, who deal with it daily tell you that, I suppose you must put credence to it.

Dr. TURNER. Yes, sir. We do. We worked with Xerox Corp., through their Weekly Reader, to do a survey of schools, grades 4 through 12. What we found appalled a lot of people who had not been intimately involved in the drug program. We found that at the 9-year-old, or fourth grade level, that 25 percent of those young people already felt some peer pressure to use drugs. So, we know we must have an effective effort at the fourth grade and below.

The Drug Enforcement Administration sponsored a series of educational materials for the kindergarten and first through third grades several years ago. They are being updated and will be reissued shortly.

Mr. HALL. Is the Department of Education finding any resistance from any of these schools for their purported help and assistance with the schools?

Dr. TURNER. I don't know about the schools you referred to, Brooklyn 10 and the ones in New York. I do know that we have had some resistance from schools in other districts because they have curriculum committees. If their curriculum committee has not approved the material, they will not allow it to be used in their schools.

This is one of the problems we face. This is the reason I think the local people meeting with the school board, with some help from their Congressman, their parent and community groups, can have an effect in getting the cooperation of the schools—it was refreshing to note this morning that Fairfax County announced that they were having a very tough antinarcotic campaign in their schools. I am beginning to see more and more school districts accept that responsibility, but you are correct, we have to start at a very early age in the prevention programs.

Mr. HALL. Thank you. I yield back the balance of my time.

Mr. LEONARD. Mr. Hall, did anybody in New York tell you that under State law the sale of up to 25 grams of marijuana is a misdemeanor and that the possession of up to 8 ounces is a misdemeanor?

Mr. HALL. I heard quite a bit of discussion from the law enforcement officers, who were very upset with the legislature in the State of New York for passing those laws.

Mr. LEONARD. We lock these people up up there and they are out with a fine. The State has to bite that bullet also.

Mr. HALL. They were very concerned about the law that had been passed by the State legislature that minimized the penalties on marijuana.

Mr. LEONARD. Twenty-five grams is almost an ounce.

Mr. HALL. They were very concerned about that. I am, too.

Thank you, Mr. Chairman.

Mr. RANGEL. Mr. Gilman.

Mr. GILMAN. Thank you, Mr. Chairman.

Dr. Turner, for a number of years the select committee has focused attention on the need to have a central, coordinated effort, an effort to develop a national strategy and an international strategy right at the top and to be in a position to be close to the President in order to implement such a strategy.

I note that you had been serving as the Director of the White House Drug Abuse Policy Office in the Office of Policy Development. I assume you are still the Director of that office, in addition to your new assignment as Special Assistant to the President for Drug Abuse Policy.

Isn't that correct?

Dr. TURNER. Yes, sir.

Mr. GILMAN. Am I correct, then, that you are truly the key person in the White House who is in charge of all of the drug problems? Is that correct? In strategy, implementation, bringing it all together, coordinating the effort?

Dr. TURNER. My office formulated the strategy and, with the help of the agencies and the Cabinet Secretaries, presented it to the President. The President accepted it, and has maintained a continuous interest in strengthening the effort. Yes, my responsibility is to insure that he gets the proper advice on drug abuse issues, regardless of whether they are international, et cetera.

Mr. GILMAN. You talked about our efforts in the Congress to create a drug czar, so to speak. I don't know if "czar" is a good term, but a drug coordinator. The Congress is interested and I have joined in that effort and I think our chairman has and I know Mr. Hughes on our own committee is the chief sponsor of that legislation—in order to have a key, central figure that we can turn to to make certain that that all of our concerns in drug enforcement, drug eradication, drug treatment, drug rehabilitation is properly being focused and undertaken and implemented at top executive levels.

Do you perceive yourself in that role today?

Dr. TURNER. I perceive myself as giving the President the advice on policy. I think the key to a successful program is Presidential involvement. We could have 15 drug czars, or whatever you want to call them. If you didn't have the President involved, we couldn't do much.

Mr. **Gilman**. I recognize that, Dr. Turner, but if I might interrupt, do you perceive yourself, and are you the chief narcotics coordinator at the White House level?

Dr. **Turner**. I have the responsibility of answering to the President for all drug coordination issues and making certain the policy is implemented.

Mr. **Gilman**. And the authority to do that?

Dr. **Turner**. I have authority vested by the Executive order that gave me that responsibility. I think the way this administration functions, with the Cabinet Councils, is somewhat different than past administrations. We have two Cabinet Councils that have the responsibility to help with coordinating, as well as to help in implementing the strategy.

Mr. **Gilman**. Do you preside over those? Are you the coordinator for both of those councils?

Dr. **Turner**. I preside over the Working Group of the Cabinet Council on Human Resources as to drug health issues. The Associate Attorney General presides over the other working group under the Cabinet Council on Legal Policy. I have the responsibility to make certain the two working groups are coordinated.

Mr. **Gilman**. You don't serve as Chairman of the Cabinet Council on Legal Policy?

Dr. **Turner**. No, the Chairman of the Cabinet Council on Legal Policy is the Attorney General. The Chairman of the Cabinet Council on Health and Human Resources is the Secretary of HHS.

Mr. **Gilman**. I notice that the Working Group on Drug Supply Reduction in the Cabinet Council, the Chairman was Rudolph Giuliani, now out of that office. Who has taken his place?

Dr. **Turner**. The Associate Attorney General, Mr. Lowell Jensen.

Mr. **Gilman**. You bring together both of those councils in a coordinated effort, the Cabinet Council on Legal Policy and the Council on Drug Abuse?

Dr. **Turner**. We bring together the findings of those two. Mr. Jensen—just as Mr. Giuliani had before that—and I have fairly regular meetings where we discuss the issues.

Mr. **Gilman**. And you also oversee our international efforts?

Dr. **Turner**. I confer with the Assistant Secretary of State, Mr. Dominick DiCarlo, on those issues. Whenever we have information there, I consult with him.

I fully accept the responsibility for the policy we have put forth, but I will tell you that your help has also been very appreciated. We have fought the battle internationally, particularly the trips we made down to South America. Your expressed concern has helped Mr. DiCarlo and myself both do our job better. I appreciate that.

Mr. **Gilman**. We appreciate your comments, the reflection. I think we are all trying to do the same thing to make a more effective policy.

With regard to that, under section 302 of the Drug Abuse, Prevention, Treatment, and Rehabilitation Act, the President was directed to establish a Strategy Council consisting of Cabinet-level appointees and non-Federal representatives to assist in the development of a long-term Federal drug strategy.

Have those appointments been made, Dr. Turner?

Dr. TURNER. The Strategy Council was not formalized by President Reagan. We checked in to the Strategy Council and the only time that the Council met in full was in 1977. We took an alternative approach of establishing a system for the formulation of policy as required by section 201(a) in that statute. We used, instead, the Cabinet Council on Human Resources and the Cabinet Council on Legal Services. We also, in order to——

Mr. GILMAN. Dr. Turner, if I might interrupt, does that fulfill the mandate set forth in section 302?

Dr. TURNER. In section 201:

> The President shall establish a system for developing recommendations with respect to policy for objectives and for establishment of priorities for federal drug abuse functions and shall coordinate the performance of said functions by federal departments and agencies.

We have the Presidential involvement. The Presidential system was not one that was compatible with the establishment of the Strategy Council. We have taken into consideration the need to get advice from outside of the Government. We developed the strategy working with the responsible Federal agencies and with the independent agencies. We then went outside to national and international experts in the field of drug abuse for advice.

Mr. Leonard personally contacted local law enforcement people for their input. We think we have pulled together a cross section of advisers that gave us a good approach to this strategy. We think we are complying with the law which calls for the President to establish a system compatible with the President's administration.

Mr. GILMAN. I appreciate all those efforts, but essentially, then, you have not appointed any Strategy Council?

Dr. TURNER. No, sir. I thought I said no at the start. We did not.

Mr. GILMAN. Doesn't the law require both a system and a Strategy Council?

Dr. TURNER. The system is set up and the Strategy Council has been superseded by the Cabinet Council of Legal Policy, Cabinet Council of Human Resources, and all the outside advisers.

Mr. GILMAN. That is not what the section says. It talks about non-Federal representatives to assist. Why is there such a reluctance to appoint such a council?

Dr. TURNER. As I said, Congressman, when I checked the records, I could not find a full Strategy Council meeting anywhere. They had one Council meeting in 1977, and obviously there were some problems with that setup. We chose a system we thought would be appropriate.

Mr. GILMAN. It seemed to me that under the former administration there were several meetings of the Strategy Council and they even issued a Strategy Council report, as I recall. This committee met with the Strategy Council members on several occasions.

Dr. TURNER. Mr. Chairman, since I was not here during that time, I would like one of my colleagues who has institutional memory to address that question, if I may, Mr. Dick Williams.

Mr. GILMAN. I would urge you to take another look at this section. If there isn't any major objection, I would hope that you would see the benefit of establishing a Strategy Council.

We certainly can't have enough people who are interested nationally in developing a proper, long-term strategy. That seems to have been the failure over a number of years. We were reacting in knee-jerk fashion to the emergencies as they occurred, just as we have reached once again in south Florida in bringing together an emergency team. It has been an effective team, but it has not addressed the overall national and international problem.

While I appreciate Mr. Leonard going out and consulting with the number of people around the countryside, it would seem to me that a formal national Strategy Council could be of a great deal of assistance to the administration. I would hope that you would take another look at that mandate that is set forth in the statute and see if we could evolve a proper team to be of assistance to the White House. I think that that could have a great deal of benefit.

Dr. TURNER. I think that, with your permission, I would like to go over that with you in detail at a later date. I think we need to do whatever is possible to get the maximum number of participants from outside the Government involved, and that is what we have tried to do, but let's discuss that later, sir.

Mr. GILMAN. Dr. Turner, I know my time is running, but in just one other area.

As we travel around to various countries and discuss these problems on eradication, we are confronted with differing statistical data bases. For example, in Colombia our people told us that production was down, that exports were down. Back here in the States we found that exports were up and production was up. We were dealing with 1981 data bases.

I would hope that you would take a look at the manner in which all of our Federal agencies gather their data and statistics on narcotics and try to have a standard, thorough compilation of statistics, everyone using the same data, and making them current and not basing our policy on 1981 data. I think that that is a major failing in our attack on this problem.

Dr. TURNER. I agree with you. We have requested an evaluation of all our statistical systems. They have been evaluated. Some have been changed. For example, the CODAP reporting is no longer required, yet most States are voluntarily doing it. The National Institute on Drug Abuse is working with California and with New York to make their system compatible with those already established systems.

We are trying. One of the most frustrating things I faced when I first came here was not being able to get information that everyone could agree with. We are in the process now of reviewing all of those and will have some information on that before long. There has been a formal review system set up.

Mr. GILMAN. We appreciate hearing that.

My time has run out, Mr. Chairman. I thank you for allowing me to extend.

Mr. RANGEL. Mr. Oxley.

Mr. OXLEY. Thank you, Mr. Chairman.

Dr. Turner, the DEA announced recently that the price of cocaine had fallen sharply on the street. It appears that the availability of cocaine is quite high today.

What plans does the administration have to combat this threat? Is there any long-range effort at trying to stem the tide to at least, if nothing else, get the price higher? As we look right now with the supply-and-demand situation, I think it is very evident that the supply is very much increased and, therefore, the price has gone down.

Would you care to comment on that?

Dr. **Turner**. I think there are two factors, Congressman. No. 1, as I mentioned previously, the use data shows a moderation of the cocaine use, which means that if you have the same supply and the consumption goes down, it results in an oversupply and the price may go down. In talking with the DEA, we think there is a combination of conditions. There is a reduction of demand in some areas and the supply has stayed constant. We know that cocaine is available.

Now, what are we doing to address that issue? We have agreements with drug-producing countries. In Peru, I do not think the agreement is being executed as efficiently as it should. Several Congressmen here today have visited Peru since that time. However, Peru now has a new agricultural minister who takes a different view of narcotic production than some of the previous ones. Also the eradication program in Peru will start using herbicides.

The Bolivians, on the 11th of August, signed an agreement to start an enforcement program in the Carapari, which is a coca-producing area of Bolivia. They have 150 people trained initially, with additional troops planned to go in.

We are going to continue to enforce our laws here and strengthen our interdiction efforts. Our national narcotic border interdiction system is going to give us a more effective border management program. We will continue our international efforts and continue our demand reduction efforts here.

We think we have to continue a full-court press in all of these areas to be effective in the overall program.

Mr. **Oxley**. Dr. Turner, what is your position personally or at least the administration's position on efforts here in Congress to cut off foreign assistance in cases where countries have consistently not cooperated with our efforts to try to stem the tide of illegal drugs coming into this country?

Dr. **Turner**. I think there are a multitude of issues, but we will not oppose section 506 of H.R. 2992, which members of this committee have been influential in processing.

Mr. **Oxley**. I thank you. Dr. Turner, it appears to me from our hearings and from my personal experience that a great deal of the problem is simply the tremendous, almost unbelievable amounts of money in cash that can be made in the drug trade.

I had an opportunity to go down to south Florida and talk with several people down there, with the Coast Guard and other agencies. When they told me about how much money an individual could make with a successful landing of a boatload of marihuana, for example, I was frankly stunned.

Having been in law enforcement myself in the past, I was still stunned because of the incredible amounts of cash that can be made by people who are very tempted, obviously, by that amount of money.

What do your studies show you in terms of the availability of cash to be made in that kind of a situation? Isn't that really the ultimate attraction to those who would break the law consistently with the chance to make that kind of money?

Dr. TURNER. Yes, sir. I think the exorbitant amount of money that can be made is having a corrupting influence on public officials, as well as on our political system in certain parts of the country.

Mr. OXLEY. Is that also true internationally as well?

Dr. TURNER. I think so. We are looking at the laundering of money and the banking agreements. We have an agreement with Switzerland, where, if there is criminal intent, we can look at some of those bank accounts.

We are asking the Panamanians to strengthen their international banking agreements. We are also looking at the organized crime drug enforcement task forces to trace the money flow. Customs also has programs which trace money flow. The goal is to make the risks and cost of doing business in illicit drugs so high that it no longer has the profits that you are talking about.

The Congress was beneficial in giving us the forfeiture acts, where we can now use forfeiture proceedings to remove the assets of the traffickers or dealers; those which we can show that they have made through drug dealing. IRS is also involved. I think the last count was they have around 44 percent of their criminal investigation people involved with the tracing of illegally obtained income.

Mr. OXLEY. Dr. Turner, my last question is, from your position, in looking at this entire international problem, what area or what country is giving us the most difficulty in trying to deal with the area for illegal drug importation into this country?

Dr. TURNER. If we look at South America, the country would have to be Colombia. We get cocaine from Colombia and they are increasing their own production of cocaine. We also get marijuana, Quaaludes, and other pills from Colombia. I think that stopping drug trafficking from Colombia has to be a high priority.

We are pursuing initiatives there. I did a teleconference in August with Colombian journalists and a second one 2 weeks ago. I can tell you the mood has changed within Colombia. There was a contract out for the Minister of Justice in Colombia, which led them to take a much more positive view to extraditing criminals to us. Mayor Ramirez of Bogota, and his wife have taken drug abuse as a personal issue, the First Lady of Colombia has also joined in the fight against drug abuse. These are changes that we could not anticipate. They are beginning to understand the corrupting nature of illegal drug profits and public attitudes have changed.

The other area would probably be Pakistan and the opium trade. The Pakis have signed agreements with us. I have not visited Pakistan, so I cannot say firsthand what is happening there, but I plan a trip during the latter part of this month or the first part of next month. I think probably Congressman Rangel may have more.

Mr. OXLEY. Thank you, Dr. Turner.

Thank you, Mr. Chairman.

Mr. RANGEL. Dr. Turner, the President of Colombia indicated to this committee that he entered into an agreement with the President of the United States in coordinating an effort to stop the cocaine trafficking.

Did the President share with you or any member of the administration the content of that agreement?

Dr. **Turner**. The subject was discussed but the actual agreement between the President and the President of Colombia is something that is between those two chief executives.

We have been told to do everything within our authority to support our Ambassador to Colombia in his efforts when he discusses the drug issues with the President of Colombia. So, in that connection we work through the Ambassador, Ambassador Lew Tambs, who was up here last week.

I discussed the issues with him. He fully believes that we are making progress. Your trip down there and with the highlighting of the concern of the Congress and with the other issues, you have been very helpful. We are giving him all the support that he requests to implement any of the agreements.

Mr. **Rangel**. Mr. Chappie.

Mr. **Chappie**. No, thank you.

Mr. **Rangel**. Mr. Hunter.

Mr. **Hunter**. Thank you, Mr. Chairman. I just had a couple of followup questions on Colombia.

In our hearings with Colombian officials it was made evident that they have considered and at least temporarily rejected the use of paraquat on their drug crops. I guess kind of a blunt question I would put to you is this. We talked about this with the Colombian officials, but it appears to me that the drug economy in Colombia is operated with the cooperation of the Colombian Government, not with their opposition. I would like your candid answer to that.

Dr. **Turner**. First of all, I don't think there has been a rejection. There was a study group from Colombia that recently went to Mexico, then came to Washington and met with the U.S. Department of Agriculture, with my office and, I think, with Members of Congress. They subsequently visited two research sites in the United States.

In my discussion with Ambassador Lew Tambs last week, his belief is that a majority of those members favored herbicidal eradication.

There has been a change of opinion in Colombia in regard to paraquat. They have a coffee blight that is affecting the coffee plants and, as I was told by a Colombian journalist, they are using paraquat to defoliate some of those plants. So, there has been a total change in attitude regarding the use of gramoxone—our paraquat is gramoxone down there—in an eradication program. I understand that the study group will be making recommendations to their President this week. Maybe they have already made their decision regarding that.

The other issue deals with officials in the government. I think that some of the legislative people there have been implicated in drug trafficking, but I believe the recent changes made by the Minister of Justice and the change in the Minister of Health's position and I think the President's position has alleviated some of that.

A notorious example was Carlos Litre. When they bought a radio station for him, their own political party, I think that woke up the politicians in Colombia. I have seen a total change in their philosophy in the last 3 months.

Mr. Hunter. So you don't think at this time that the drug trade controls the Colombian Government?

Dr. Turner. I can't answer that. I think there is still enough innuendos to insinuate that there is some corruption within the political process there.

Mr. Hunter. Thank you, Mr. Chairman.

Mr. Rangel. Mr. Guarini.

Mr. Guarini. Thank you. Dr. Turner, I view your job as one of the most important jobs we have in our society, and probably the most difficult as well. I would like to ask you whether or not you feel that we are winning the war against our drug problem?

Dr. Turner. Personally, I think we have made significant inroads. I think we have taken that continuous increase in all drug abuse indicators, and we have moderated most and are turning them down.

I think the attitude is pervasive throughout our society that the local people are more willing to give the enforcement people help. I think we have seen a change to where instead of pointing a finger at other responsibilities, the communities are beginning to say that we all share the responsibility.

I believe we are on the right track with added enforcement efforts and local priorities. We are using a full-court press by putting the pressure internationally to reduce the flow of drugs, improving our border interdiction efforts, our domestic law enforcement, and our education and prevention efforts.

I think that we have the right approach. I believe, with the help of Congress, we are beginning to see that approach take effect.

Mr. Rangel. If the gentleman would yield, because we are having difficulty just with two questions. I know about all these signals and moderation and getting a handle on the problem, but in the two areas—that is, availability of cocaine and heroin and the number of addicts—is it true that there is more heroin on the streets today than there was in the last 2 years, more cocaine that is available on the streets, and more use of these two drugs, notwithstanding all of the other accomplishments.

In those two areas—and I am leaving marijuana alone because I think it is uncontradicted that there is more use of marijuana—but cocaine and heroin, is there more now available and on the streets than last year and is there more on the streets last year than the year before last?

Mr. Leonard. I won't accept that the demand isn't down, but all indicators that I have, Mr. Rangel, are that there is more pot on the street——

Mr. Rangel. No, no, no. Mr. Leonard, it is going to be difficult getting through this hearing, but we are going to get answers just to two questions and then I will pass on all the rest. Let's try just this first one.

Mr. Leonard. Go ahead.

Mr. Rangel. Cocaine. Is there more cocaine on the street in 1983 than there was in 1982?

Mr. Leonard. I was getting to that. The indicators are there is more cocaine.

Mr. Rangel. Let me try the next question, and then I am going to yield back my time.

Mr. GUARINI. No; you are following my line of questions very well.

Mr. RANGEL. Well, it has been difficult.

Heroin. Is there more heroin on the streets of the 50 States of the United States of America today, 1983, than there was last year?

Mr. LEONARD. I am not going to answer for the 50 States, Mr. Rangel——

Mr. RANGEL. Strike out "50 States." In the United States of America, is there more heroin that is coming to the United States than there was last year.

Mr. LEONARD. The people I talk to say there is a slight increase in heroin, and the hospital-related indicators say there are more incidents.

Mr. RANGEL. I yield back.

You will have plenty of time to expand, but I just want to thank you for those answers because that is what we have been getting in terms of our local hearings.

Mr. GUARINI. So, things are worse as far as the availability of drugs on the streets, so that we are not winning the war against drug abuse. Is that correct?

Dr. TURNER. I cannot accept the fact that things are worse.

Mr. GUARINI. Well, are there more addicts? If there is more cocaine and heroin on the streets, do you think that there are more addicts in our society today than there were last year and the year before?

Dr. TURNER. I think we are seeing more emergency room incidents in certain areas because we have a smaller group of people using more concentrated forms of the drugs. I think the trend toward using cocaine and heroin and combinations of drugs has contributed significantly to that. But if we look at the absolute data, which Dr. Pollin will have tomorrow from the health surveys, they will show there is a decrease in the use.

Now, whether or not that is going to say the supply is up or down does not, in my mind, focus on the essential point. The point is taking the user away from the drugs. I think that shows in the date. NIDA's position is very straightforward.

In recent months the overall trend—and heroin was mentioned—has begun to show signs of leveling off. I think that it has leveled off in New York and Los Angeles, small decreases in Philadelphia. This is all according to their data. Only Detroit and Phoenix are showing a strong increase.

Mr. GUARINI. Dr. Turner, we only have a limited amount of time. I would just like to simply ask whether or not we are worse off today than we were last year and the year before as far as the availability of drugs in our society and the use of drugs in our society.

Dr. TURNER. I think we are better off.

Mr. GUARINI. You think we are better off?

Dr. TURNER. I think we are better off today than we were.

Mr. GUARINI. Therefore, it is your opinion that we are winning the war against drugs?

Dr. TURNER. We are looking at all drugs.

Mr. GUARINI. In looking at all drugs, where are we worse off?

Dr. TURNER. I think we are better off.

Mr. GUARINI. Well, you said in looking at all drugs. In some drugs are we worse off?

Dr. TURNER. If you look at the household survey, which is our best data on household use and on use throughout the country, and if you look at the total population, from 1979 in comparing to 1982, the only area that showed a significant increase was the mild stimulants, phenylpropanolamine type, and over-the-counter diet pills.

Mr. GUARINI. You don't think that cocaine is worse today in our society than it was a year ago?

Dr. TURNER. I think the media and everyone is looking more intensely at it. I think the overall data that shows the use pattern has leveled off and going down. I will stick by that. That doesn't say that it may not be more available. If you have fewer people using it and you have a constant supply, there is more supply out there.

Mr. GUARINI. So that you think that enforcement is effective in our country today and that we are winning the war on drugs?

Dr. TURNER. I think we had about a 10-year period where we went through some very traumatic times. We had a spigot coming up from South America that was not turned off. I think our enforcement people are turning that off, but we have to give them time to work. The South Florida Task Force was only announced in 1982, and without the help of the Congress we wouldn't have had the exception to posse comitatus.

We just put our investigative task forces in place in 1982, and we have just put the national narcotic border interdiction system in place. I think they are the appropriate responses, and I think they will yield results.

Mr. GUARINI. Do you have any authority over the South Florida Task Force and the other task forces?

Dr. TURNER. I have no operational authority, but if I need assistance from them, I can get it.

Mr. GUARINI. Well, do you meet with them regularly and plan strategy with them regularly?

Dr. TURNER. I meet with the policy group. My deputy meets with the operational group on a regular basis.

Mr. GUARINI. But that is under your supervision and under your authority, is that correct?

Dr. TURNER. No, the South Florida Task Force was set up under the Vice President, with the President designating the Vice President to coordinate those efforts. The national narcotic border interdiction system is set up under the Vice President, with a policy group of Cabinet-level officials, which I sit on, and with a coordinating group of operational people, which my deputy sits on.

Mr. GUARINI. That sounds very complicated. Let me ask you this. You are the Special Assistant to the President. Do you have direct access to the President?

Dr. TURNER. Well, the last time I saw the President was a full Cabinet meeting on the 17th of this month, and I will see the President again this afternoon.

Mr. GUARINI. Let me ask you this. In the last 2½ years or a little over 2 years you have been in office, how many meetings have you had with the President in which you have discussed drug strategy and the meetings were held solely for the purpose of discussing drug strategy?

Dr. **Turner**. Private meetings with the President? There have been two, but when we have Cabinet-level meetings that deal with drug issues, I am there and I participate.

Mr. **Guarini**. I didn't ask you that because when you meet with the Cabinet——

Dr. **Turner**. I said private, too, sir.

Mr. **Guarini**. You had two private meetings in which you discussed drug strategy?

Dr. **Turner**. Yes, sir.

Mr. **Guarini**. It was held only between you and the President solely for the purpose of drug strategy?

Dr. **Turner**. Well, let me say that on the first meeting Mr. Leonard was in the room, but the President and I discussed it personally. The second time we delivered the strategy and the President and I discussed the strategy, and just the President and I were at that meeting.

Mr. **Guarini**. So, therefore, you are down to one meeting, then?

Dr. **Turner**. Well, if you say one-on-one with nobody else in the room, which is a rarity with the President, yes.

Mr. **Guarini**. When were those two occasions that you discussed drugs? What dates?

Dr. **Turner**. Well, I think those were November 17, if my memory serves me correct, 1981 and then in October 1982. However, as drug abuse policy adviser, I have better access to the President now than any past drug abuse adviser has had.

Mr. **Guarini**. Well, you say that, but you haven't met with the President in a year concerning drug strategy in our country.

Dr. **Turner**. Let's not disregard the many other meetings, Congressman, where we——

Mr. **Guarini**. You are the Special Assistant to the President of the United States. You are not just an ordinary public official.

Dr. **Turner**. Let me explain, sir. When we take issues through the Cabinet Council, my input is there. That input goes in to the President, and when that material comes to the Cabinet meeting, we are there to discuss those drug abuse issues.

Mr. **Gilman**. Would the gentleman yield?

Mr. **Guarini**. Yes. I think this should be pursued more.

Mr. **Gilman**. Dr. Turner, how do you make that input to the President if you haven't met with him in over 1 year?

Dr. **Turner**. I didn't say I had not met with the President in over a year, Congressman. I was with the President the 17th of this month.

Mr. **Gilman**. The gentleman from New Jersey asked you specifically how often——

Dr. **Turner**. The gentleman phrased the question very succinctly, one-on-one, nobody else in the room, and I answered that precisely.

Mr. **Gilman**. Have you met in a small strategy conference with the President, instead of the entire Council out there, on narcotics recently?

Dr. **Turner**. I meet regularly with Mr. Meese on the narcotic matters, and then he discusses them with the President. If my presence is needed, I am there.

Mr. **Gilman**. When was your presence last needed on narcotics?

Dr. **Turner**. We had a full Cabinet meeting on the 17th.

Mr. **Gilman**. On narcotics?

Dr. **Turner**. On narcotics.

Mr. **Gilman**. On the 17th of when, sir?

Dr. **Turner**. Of this month. I am sorry, last month.

Mr. **Gilman**. And that was a full Cabinet meeting on narcotics?

Dr. **Turner**. That was a full Cabinet meeting.

Mr. **Guarini**. Only on the purpose of narcotics?

Dr. **Turner**. Narcotics was the primary issue. There was a 10-minute section devoted to other issues.

Mr. **Guarini**. Well, how long did you spend on the session concerning narcotics?

Dr. **Turner**. Gosh, I did not realize I was going to have to recall that.

Mr. **Guarini**. Well, to the best of your recollection.

Dr. **Turner**. It seems to me like the Cabinet meeting lasted for about 45 minutes and drug issues were discussed for, I would say, in the neighborhood of 35 minutes.

Mr. **Guarini**. So, 35 minutes you spent discussing national strategy on drugs——

Dr. **Turner**. Particular issues, yes.

Mr. **Guarini** [continuing]. Which included health, education, law enforcement, foreign affairs and other drug-related issues? Is that correct?

Dr. **Turner**. No, sir; we did not discuss all those issues. That particular Cabinet Council was devoted to a particular one. There is one that was a meeting——

Mr. **Guarini**. All right. The last time you said you met with the President was in October 1982. How long did that meeting last?

Dr. **Turner**. It was about 10 minutes.

Mr. **Guarini**. About 10 minutes. And you discussed all the incidents of strategy concerning drug abuse eradication in the United States? Is that correct?

Dr. **Turner**. Congressman, you and I both know it is impossible to discuss all those issues in 10 minutes. We deal with specifics.

Mr. **Guarini**. Of course it is. What I am trying to get out of you is as the Special Assistant to the President—are you really the Special Assistant to the President?

Dr. **Turner**. The President has set up a system in his administration to take policy issues through the Cabinet Council, through the Cabinet, and then to the President. I participate fully in those lengthy discussions to distill the material taken to the President. I can assure you that my input gets to the President.

Mr. **Gilman**. If the gentleman would yield again, is your input through Mr. Meese to the President? Is that the primary input besides the Cabinet meetings?

Dr. **Turner**. Primarily, yes.

Mr. **Gilman**. Thank you.

I thank the gentleman for yielding.

Mr. **Guarini**. So you have a link to the President as a Special Assistant? Is that correct?

Dr. **Turner**. I probably, as a Special Assistant, have as good access to the President as any Special Assistant in the building.

Mr. **Guarini**. Well, have you drawn up a blueprint on the war against drug abuse in our country that specifically lays out a course over the next couple of years as to what we should do and where we are going?

Dr. **Turner**. Yes, sir. We have the Federal Strategy of 1982, which the President accepted and put a letter into it. This is the first Federal Strategy any President has accepted as his own personal strategy.

We have an implementation review underway now and, as I mentioned in my testimony, that implementation review of the health issues would be pulled together shortly. Implementation on the enforcement side is coming together. I would be happy to share the report with members of the committee and would appreciate your counsel.

Mr. **Guarini**. In that 10 minutes you were able to set forth and explain to him directly what your national strategy was? Is that correct?

Dr. **Turner**. The President is aware of his strategy. The first meeting I had with the President, we discussed researchers, we discussed individual initiatives, nationally and internationally, and I asked the President, "Mr. President, with your knowledge of drugs, why do you need me?"

Mr. **Guarini**. Let me ask you, did you ever discuss the question as to whether or not there is cooperation between the local and State and Federal authorities in eradicating the drug problem in our country?

Dr. **Turner**. I think my deputy, Mr. Leonard, would like to answer that.

Mr. **Leonard**. I have had several conversations with Mr. Meese on that. This is one of those issues where you are damned if you do and you are damned if you don't. If you talk to some of the local police, cooperation is great. If you talk to other local police, they never see a Federal agent. Frankly, I don't know who to believe.

Mr. **Rangel**. If Mr. Guarini would permit. If the largest concentration and targeting is in southern Florida—and I will recognize you for another round——

Mr. **Guarini**. You can certainly discuss that.

Mr. **Rangel** [continuing]. Then Mr. Lewis represents that area. The question that you raise is a very key question.

Would you yield and let Mr. Lewis share with Mr. Leonard what the observations were in our hearings in southern Florida, where we have the highest concentration of Federal law enforcement?

Mr. **Guarini**. I certainly yield to Mr. Lewis on the issue of cooperation between the State, Federal, and local officials there.

Mr. **Lewis**. Thank you, Mr. Guarini.

Mr. Leonard, in our hearings last month in Florida, it was very obvious to the Select Committee that the cooperation between the Federal officials and the local officials left much to be desired. In fact, there seemed to be little cooperation, if any.

Since that meeting in south Florida, which was a 2-day hearing by this committee, I have been informed by several sheriffs that all of a sudden there is a communication link now between the south Florida task force and a lot of the Federal agencies, as well as the local law enforcement officers. Such information as certain targets are moving into the northwest area of Martin County, some are moving into Collier County in south Florida, some are moving into Highlands County and is being shared. We suggest your assistance. We expect dumps or landings in these areas, which is a problem they have never had before.

The chairman has charged me with the responsibility of holding a conference with the south Florida law enforcement officers to see if we can't bridge this gap between the Federal officers and the local officers.

Now, there are a number of problems that I have been able to find just on a cursory investigation. There is a lack of trust, a lack of "Well, we will handle that," or "You can't make that bust until you call us," or this sort of thing.

This has certainly hurt the morale of those local officers, particularly the sheriffs, especially if you look at their records because you will see that they made the largest money drug bust in history, the largest marihuana bust in history, and the largest cocaine bust in history, all within the last 6 months.

This has been done, the majority of it, by local law enforcement officers and in some cases, in due respect, to some help from the Federal officers. But there is not a sense of cohesiveness between them. They do not feel it. They feel that they are being abused as far as law enforcement when they are given the responsibility by their electorate to crack down on narcotics smuggling.

In reference to your earlier comment about your not knowing who to believe, I can give you a list of names of who to believe because we are going to hold that conference soon, Mr. Leonard, and when we do, we are going to issue a special invitation to you to attend.

Mr. **Leonard**. I will be glad to come down. I went down there in 1981 and we had a conference, and because of that conference we got the South Florida Task Force, and because of the South Florida Task Force NNBIS was born, and because of NNBIS you are seeing better cooperation and better communication.

That was the problem all along, Mr. Lewis. We did not have an adequate communication system. I will agree with you that there has always been distrust between the Federal officers and the locals. I speak from experience. I have been a cop all my life. But that is not true just on the local side. It is sometimes true on the Federal side. But that is not a good excuse to say we can't get along.

We have to overcome that by talking to each other, and they are talking to each other now. There are more cooperative efforts going on. I just came back from Florida. There is more going on. People expected this to turn around overnight. We have been dealing with this thing for 20 years. Believe it or not, cops have been dealing with it alone. We are society's garbage men.

Mr. **Lewis**. Mr. Leonard, you don't have to give me a lesson in law enforcement. I understand that. What you are saying may be true, but it certainly hasn't been true in the last 18 months, and I don't want you to sit there and try to tell me it is true when I have been involved in it.

The communication and the cooperation in south Florida leaves much to be desired even today. Now, you may have been down there, but as I mention to you, the chairman did point out that we had a problem. This was brought out before the hearing, and since that hearing, there have been indications of more cooperation. What in name of heaven happened 18 months ago, and what happened the 16 months before we went down there?

I know that you have been in the business a long time, but you just can't take one group of Federal officials and expect the locals to give you all their assistance. You are not going to get any cooperation at all unless the locals are a part of the team. That is what they want to be, and that is what we intend to do with our conferences. We will probably come up with a team, and we want you to be there to hear their observations as well.

Mr. **Leonard**. That is my job.

Mr. **Rangel**. If the gentleman would yield, let me see whether we can spell this out.

We had hearings in southern Florida in October. Mr. Lewis invited five sheriffs. They had a panel. They testified in front of the committee as to how serious the problem of narcotics was. To a man, they said it was worse than they have ever seen it, notwithstanding the fact that they lauded the Federal effort.

In their testimony they revealed to this committee that in all the time that the Federal officials were there, that they had never met with the Federal officials in an effort to coordinate their law enforcement strategy.

I think Mr. Lewis is saying that since that hearing, there have been people—and perhaps you were included in that number—from the Federal Government that have reached out to them. But we are talking about from the establishment of the Federal South Florida Task Force until October of this year.

So, if you just picked up the phone and called them yesterday, there would be a substantial improvement in the communication because they said they never had a meeting.

Mr. **Leonard**. I don't know about a meeting, Mr. Rangel, but I do know that this thing has been ongoing and getting better for 18 months. This didn't happen overnight.

Mr. **Rangel**. It must be a semantic problem. If you don't know about a meeting, what are we talking about? These are people who have been elected to enforce the local and State laws. They are sheriffs. They have the responsibility to arrest people violating the law. They said they never had a meeting. You said, "I don't know about a meeting, but it is getting better."

What do you have in lieu of a meeting?

Mr. **Leonard**. If I come to the sheriff of a county on a one-to-one basis and ask for his assistance, I don't believe I have to have all the sheriffs from northern Florida there. Let me give you a perfect example of what I am saying.

I went up to New York about 6 months ago and spoke to the city police to try a trial program using Federal officers and city officers. I got in trouble with the people in Jersey because I didn't include them. It was only an experimental program, and yet I say you are damned if you do and you are damned if you don't.

Mr. **Rangel**. I was really talking, Mr. Leonard, about southern Florida. Could you share with this committee what the Federal task force has done in terms of coordinating their efforts with the sheriffs who have been elected for the five counties that are described as southern Florida?

Mr. **Leonard**. I know for one thing that the task force has been trying for quite a while to get a man from the Federal Bureau of Law Enforcement into the program down here and into the communications center. It is Dade County.

Mr. **Rangel**. Thank you.

Mr. Lewis.

Mr. **Lewis**. I would just like to state, Mr. Leonard, that the sheriffs, when they appeared before this panel—and these are all south county sheriffs, who are all involved in these major drug busts that I mentioned to you, sometimes with and sometimes without the assistance of the Feds—their concern is that, "Yeah, we were advised that the Federal task force would be here and we could use those people. We call them and say 'Hey, we are ready to make the bust.' They say, 'Now hold off, we will handle that.' " They are shoved out, and go back to business as usual.

These sheriffs are very much concerned that they have, just like the Federal people do, their lives on the line when they are stationed out there. Narc officers do a lot of undercover work, but then they are not informed, not communicating back and forth with the Feds to know when something is going to happen or when they should expect something to happen.

True, since the hearing, communication has happened on three occasions that I know of. I was made aware of this over the past weekend because I made some telephone calls to find out. But I am not satisfied that there is cohesive cooperation between the Federal officers and local law enforcement officers in south Florida. We are going to get to the bottom of this and see if we can't get some communication.

I think it is past time where a particular sheriff becomes a hero overnight or a particular Federal officer becomes a hero overnight because of a drug bust. I think we have to get together with this thing. If we don't get together with our law enforcement, we certainly are not going to convince the people we are trying to do the job.

The people of south Florida right now do not feel that the overall job is being done. Yes, there is a niche in what has happened, but let me tell you this. When I have heard the questions about heroin on the street and coke on the street and marijuana on the street, there is no doubt that the amount of it has increased. I have talked to young people and I have talked to other people who have been involved in this stuff.

Believe me, sir, we have a real problem of narcotics production from South America. I saw the size of these crops, and it is meeting anything that we knock out coming into our shores and still meeting or exceeding the demand that is placed upon the drug traffickers.

Dr. TURNER. Mr. Lewis, I think that we always need better coordination and better communications. Our goal is to strive for that, but I think it is going to be extremely difficult without the assistance from your personal office and from the committee and the Congress, as well as the administration, to insure that our coordination is better.

I am not certain that we will ever have coordination as good as I would like it or as good as you would like it, but we certainly should continue to strive for improvement and pool our resources and put the pressure on to ensure that we get it. I applaud your efforts to get better communication, and I will support those efforts.

Mr. LEWIS. I thank you, Dr. Turner, but I certainly hope—there are only two committees, the Judiciary Committee and this committee, that put forth the effort to help in the war against drugs, expedited by Mr. Leonard and yourself.

I certainly get the feeling that an adversarial relationship exists here. Nobody is here to make anyone look bad, in my judgment, but I certainly think we have to understand that we get the inputs and we expect the answers. We don't expect you to gloss over the answer. We expect a direct answer. If you need help, fine.

If I may, Mr. Guarini, I would like to ask Dr. Turner another question. Given your position in the White House, budgetary rate do you have, Dr. Turner, with the Coast Guard, the DEA, the NNBIS, NIDA, and so forth?

Dr. TURNER. My budget advice goes to the President. I would say that I would like to encourage this committee to look at the reductions that the President's budget has experienced in the area of research and training at NIDA and NIAAA. We had a cut there, made by the Congress. Our input has been to the President. I think that our input has been honored. If you will look at the commitment we have made to law enforcement, the budget has gone up. I think if you will look at the commitment from some of the other areas, it has gone up.

Mr. LEWIS. Just to go back to our hearing again in south Florida, with the heads of the agencies who appeared before the committee when the question was asked by another Congressman from south Florida as to why he didn't ask for more manpower and more funds, which we understand most agencies do anyway, it had to be dug out of him that yes, they do need more manpower, and they do need more funds.

Now, if we have as a No. 1 priority fighting the war on drugs, why aren't these commitments met?

Dr. TURNER. I think if I were an agency head, I would always want more money. I believe that the President's requests for appropriations, supported by the Congress, have been adequate. But I think that if we find there is an area where there needs to be a review, I will be happy to get with you and we will look at it.

Incidentally, my office prepares a crosscut of the budget, which I will be happy to provide a copy to you.

Mr. LEWIS. Do you have a direct input or coordination with the budgetary requests from the various agencies——

Dr. TURNER. Yes, sir.

Mr. LEWIS [continuing]. On the fight against drugs? Do you have the opportunity to discuss these with the President or at the Cabinet meetings?

Dr. TURNER. I discuss the issues. They are submitted to the President, yes.

Mr. LEWIS. Let me go one step further. Do you discuss these with the Office of Management and Budget?

Dr. TURNER. Well, a member of my staff discusses them with the Office of Management and Budget, but I reserve the right to go straight to Mr. Meese and to the President with my recommendations.

Mr. LEWIS. Are any cuts made in the budget request that you object to?

Dr. TURNER. I have supported the President's budget. Some of the areas have taken what has been perceived as cuts. Some have increased significantly.

Mr. LEWIS. Mr. Chairman, I yield back to Mr. Guarini.

Mr. GUARINI. Just to follow on the budget, isn't it true that research is at a 1980 level, that we had cut back NIDA and that we are no further into research than they were 3 years ago, that there is not more research being done in drug abuse?

Dr. TURNER. I don't have the 1980 data in front of me, Congressman. I would be happy to provide it to you. I notice that our request, the administration's request, for NIDA research has been cut 18 percent of the amount that we had increased it.

I am committed to strong research at NIDA. I think that in some of the areas where the budget has been cut, some of the funding went into other forms of support, but we did request an 18-percent increase in NIDA's research.

Mr. GUARINI. Let's take your law enforcement request, considering the fact that things are certainly no better than they were before and we have a tremendous problem in our country. Isn't it true that the law enforcement budget just keeps pace with what you have had in previous years?

Dr. TURNER. Well, if you consider from 1980, which I do have those figures, to 1983, an increase from roughly $550 million to over $1 billion, then I guess your answer is correct. But I don't agree. I think that is a significant increase.

Mr. GUARINI. Of course, it all depends on the way we figure this, but we are fighting a $100 billion industry, more or less, isn't that correct?

Dr. TURNER. I can't accept the fact of a $100 billion industry.

Mr. RANGEL. I have the same figures that Mr. Guarini has, so if we are wrong, we want to be wrong because we have cutbacks in customs and we can't find out the increases in the FBI. Could you just, in a more general way, outline where this increase has been in law enforcement activities?

Dr. TURNER. As I said previously, Mr. Chairman, my office has a breakdown of drug law enforcement as included in the President's fiscal year 1984 budget. I don't have the breakdown in front of me. I have the figures and I will be happy to provide them to you for the record.

Mr. **Rangel**. OK. I will ask staff, while we are doing that, to share with you the figures we have, where we don't even see real increases considering inflation.

[The information follows:]

SOURCE: DRUG ABUSE POLICY OFFICE, December 1, 1983

Based on FY 1984 Budget
(millions of $)

BUDGET CROSS-CUT: FEDERAL DRUG ABUSE PROGRAMS

TOTAL PROGRAM SUMMARY

AGENCY	FY 1980			FY 1981			FY 1982			FY 1983			FY 1984		
	BA	OBL	OUTL	BA	OBL	OUTL	BA	OBL	OUTL	BA	OBL	OUTL	BA	OBL	OUTL
Drug Abuse Policy, DPS/OPD	.3	.3	.3	.2	.2	.2	.2	.2	.2	.2	.2	.2	.2	.2	.2
HHS:															
NIDA	272.2	272.2	321.2	243.9	243.9	274.6	56.4	56.4	176.6	61.4	61.4	67.0	71.7	71.7	68.3 *
NIMH	8.9	8.9	8.9	8.4	8.4	8.4	*	*	*	*	*	*	*	*	* *
SSA	.51	.51	.51	.47	.47	.47	.63	.57	.35	.57	.57	.57	.62	.62	.62
OHD	15.3	15.3	15.3	4.7	4.7	4.7	*	*	*	*	*	*	-	-	- *
Department of Education	13.6	13.6	12.5	13.9	13.9	14.0	12.8	12.8	12.9	2.8*	2.8*	3.0*	2.8	2.8	2.8 *
Veterans Administration	52.8	52.8	52.8	55.2	55.2	55.2	55.8	55.8	55.8	55.8	55.8	55.8	55.8	55.8	55.8
JUSTICE: (OCDE-Direct)	-	-	-	-	-	-	-	-	-	.2	.2	.19	2.7	1.03	.99
BOP	73.8	73.8	74.8	85.3	85.3	84.8	89.1	89.1	88.1	96.8	96.8	95.7	100.4	100.4	99.3
LEAA/OJARS	27.0	27.0	25.1	-	-	12.9	4.1	4.1	5.2	.3	.3	3.1	4.3	4.3	1.8
DEA	201.7	200.7	200.7	212.7	214.3	215.0	244.1	246.7	221.3	283.2	282.6	276.5	303.0	303.0	295.4
FBI	4.7	4.7	4.7	8.3	8.3	8.3	40.0	40.0	40.0	105.6	102.6	102.6	83.7	83.7	83.7
INS	2.2	2.2	2.2	2.2	2.2	2.2	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4
U.S. Marshal Service	-	-	-	-	-	-	-	-	-	.7	.7	.6	.8	.8	.8
Justice (Criminal Div)	1.57	1.57	1.57	1.81	1.81	1.81	2.03	2.03	2.03	2.17	2.17	2.17	2.07	2.07	2.17
U.S. Attorneys	15.7	15.4	15.4	18.8	18.4	18.4	19.9	19.9	19.5	42.7	31.1	30.4	44.6	44.6	43.7
Department of State (INM)	38.5	38.4	26.9	35.5	35.5	35.9	36.7	35.1	42.9	36.7	36.7	35.4	53.0	53.0	41.5
AID (Direct)+	-	-	-	-	-	-	15.7	15.7	.17	9.2	9.2	10.6	11.7	11.7	12.5 +
Department of Defense	29.2	29.2	29.2	33.6	33.6	33.6	58.7	58.7	58.7	74.3	74.3	74.3	76.2#	76.2#	76.2#
Department of Transportation:															
FAA	.67	.67	.64	.69	.69	.69	1.1	1.1	.97	.85	.85	.82	.98	.98	.95
Coast Guard	102.4	102.4	102.4	160.1	160.1	160.1	172.6	172.6	172.6	194.4	194.4	194.4	211.3	211.3	211.3
NHTSA	.40	.40	.27	.05	.05	.05	.02	.02	.02	-	-	-	.34	.34	.34
Federal Rail. Admin.	-	-	-	-	-	-	.05	.05	.05	.1	.1	.1	.27	.27	.27
Department of Treasury:															
IRS	14.2	14.2	14.2	34.7	34.7	34.7	43.5	43.5	42.7	52.7	52.7	51.8	65.9	65.9	64.7
Customs	81.0	81.0	79.0	144.0	144.0	142.0	196.0	196.0	193.0	236.0	236.0	240.0	275.0	275.0	272.0
BATF	-	-	-	-	-	-	1.5	.5	.5	4.6	4.6	4.6	8.6	8.6	8.6
Department of Labor	1.41	1.41	1.41	3.35	3.35	3.35	1.17	1.17	1.17	1.11	1.11	1.11	1.1	1.1	1.1
Department of Agriculture	2.0	2.0	2.0	1.7	1.7	1.7	1.7	1.7	1.7	2.7	2.7	2.7	3.0	3.0	3.0
FDA	1.5	1.5	1.5	1.4	1.4	1.4	.8	.8	.8	.7	.7	.7	.7	.7	.7
ACTION	1.7	1.7	1.7	2.5	2.5	2.5	4.6	4.6	4.6	4.7	4.7	4.7	5.9	5.9	5.9
TOTAL	963.3	961.9	995.2	1,074	1,075	1,117	1,062	1,062	1,144	1,273	1,258	1,261	1,389	1,387	1,357 *

Includes reimbursements from OCDE task force budget in FY83 and FY84.
*-Does not include ADAMHA block grants to states-Drug funds FY82 min$78/max$146; FY83 min$79/max$170; FY84 min$70/max$175.
#-Does not include drug law enforcement support for FY84.
+-Does not include AID projects which indirectly affect production-FY82 $7.4; FY83 $10.0; FY84 $7.5.

DRUG LAW ENFORCEMENT FUNDING: LAW ENFORCEMENT SUMMARY

Based on FY 1984 Budget
(millions of $)

	FY 1980			FY 1981			FY 1982			FY 1983			FY 1984		
AGENCY	BA	OBL	OUTL	BA	OBL	OUTL	BA	OBL	OUTL	BA	OBL	OUTL	BA	OBL	OUTL
Drug Policy, DPS/OPD															
HHS:															
NIDA															
NIMH															
NIAAA															
SSA															
OHD															
Department of Education															
Veterans Administration															
JUSTICE: (OCDE-Direct)	-	-	-	-	-	-	-	-	-	.2	.2	.19	2.7	1.03	.99
BOP	70.9	70.9	72.1	82.3	82.3	81.4	86.2	86.2	85.3	93.8	93.8	92.8	97.3	97.3	96.3
LEAA/OJARS	17.8	17.8	15.0	-	-	11.1	-	-	3.6	-	-	-	-	-	-
DEA	201.7	200.7	200.7	212.7	214.3	215.0	244.1	246.7	221.3	283.2	282.6	276.5	303.0	303.0	295.4
FBI	4.7	4.7	4.7	8.3	8.3	8.3	40.0	40.0	40.0	105.6	102.6	102.6	83.7	83.7	83.7
INS	2.2	2.2	2.2	2.2	2.2	2.2	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4
U.S. Marshal Service	-	-	-	-	-	-	-	-	-	.7	.7	.6	.8	.8	.8
Justice (Criminal Div)	1.57	1.57	1.57	1.81	1.81	1.81	2.03	2.03	2.03	2.17	2.17	2.17	2.07	2.07	2.17
U.S. Attorneys	15.7	15.4	15.4	18.8	18.4	18.4	19.9	19.9	19.5	42.7	31.1	30.4	44.6	44.6	43.7
Department of State (INM)	38.5	38.4	26.9	35.5	35.5	35.9	36.7	35.1	42.3	36.7	36.7	35.4	53.0	53.0	41.5
AID (Direct)*	-	-	-	-	-	-	15.7	15.7	.17	9.2	9.2	10.6	11.7	11.7	12.5*
Department of Defense	-	-	-	-	-	-	1.1	1.1	1.1	2.1	2.1	2.1	#	#	#
Department of Transportation															
FAA	.4	.4	.38	.41	.41	.39	.44	.44	.44	.47	.47	.46	.5	.5	.49
Coast Guard	101.4	101.4	101.4	159.1	159.1	159.1	171.6	171.6	171.6	193.3	193.3	193.3	210.2	210.2	210.2
NHTSA															
Federal Rail. Admin.															
Department of Treasury:															
IRS	14.2	14.2	14.2	34.7	34.7	34.7	43.5	43.5	42.7	52.7	52.7	51.8	65.9	65.9	64.7
Customs	81.0	81.0	79.0	144.0	144.0	142.0	196.0	196.0	193.0	236.0	236.0	240.0	275.0	275.0	272.0
BATF	-	-	-	-	-	-	1.5	.5	.5	4.6	4.6	4.6	8.6	8.6	8.6
Department of Labor															
Department of Agriculture	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	2.4	2.4	2.4	2.7	2.7	2.7
FDA	1.5	1.5	1.5	1.4	1.4	1.4	.8	.8	.8	.7	.7	.7	.7	.7	.7
ACTION															
TOTAL	553.0	553.0	436.5	702.7	703.9	713.6	863.4	863.4	828.1	1,069	1,054	1,049	1,165	1,163	1,139

Includes reimbursements from OCDE task force budget in FY83 and FY84.
#-Does not include drug law enforcement support for FY84.
*-Does not include AID projects which indirectly affect production-FY82 $7.4; FY83 $10.0; FY 84 $7.5.

DRUG ABUSE PREVENTION AND HEALTH-RELATED FUNDING: TREATMENT AND PREVENTION SUMMARY

Based on FY 1984 Budget
(millions of $)

	FY 1980			FY 1981			FY 1982			FY 1983			FY 1984			
AGENCY	BA	OBL	OUTL	BA	OBL	OUTL	BA	OBL	OUTL	BA	OBL	OUTL	BA	OBL	OUTL	
Drug Abuse Policy, DPS/OPD	.3	.3	.3	.2	.2	.2	.2	.2	.2	.2	.2	.2	.2	.2	.2	
HHS:																
NIDA	272.2	272.2	321.2	243.9	243.9	274.6	56.4	56.4	176.6	61.4	61.4	67.0	71.7	71.7	68.3	*
NIMH	8.9	8.9	8.9	8.4	8.4	8.4	*	*	*	*	*	*	*	*	*	*
NIAAA																
SSA	.51	.51	.51	.47	.47	.47	.63	.57	.35	.57	.57	.57	.62	.62	.62	
OHD	15.3	15.3	15.3	4.7	4.7	4.7	*	*	*	*	*	*	-	-	-	*
Department of Education	13.6	13.6	12.5	13.9	13.9	14.0	12.8	12.8	12.9	2.8*	2.8*	3.8*	2.8	2.8	2.8	
Veterans Administration	52.8	52.8	52.8	55.2	55.2	55.2	55.8	55.8	55.8	55.8	55.8	55.8	55.8	55.8	55.8	
JUSTICE:																
BOP	2.9	2.9	2.7	3.0	3.0	2.9	2.9	2.9	2.8	3.0	3.0	3.0	3.1	3.1	3.0	
LEAA/OJARS	9.2	9.2	10.1	-	-	1.8	4.1	4.1	1.6	.3	.3	3.1	4.3	4.3	1.8	
DEA																
FBI																
INS																
Justice (Criminal Div)																
U.S. Attorneys																
Department of State (INM)																
AID																
Department of Defense	29.2	29.2	29.2	33.6	33.6	33.6	57.6	57.6	57.6	72.2	72.2	72.2	76.2	76.2	76.2	
Department of Transportation																
FAA	.27	.27	.26	.28	.28	.30	.57	.57	.53	.38	.38	.36	.48	.48	.46	
Coast Guard	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.1	1.1	1.1	1.1	1.1	1.1	
NHTSA	.40	.40	.27	.05	.05	.05	.02	.02	.02	-	-	-	.34	.34	.20	
Federal Rail. Admin.	-	-	-	-	-	-	.05	.05	.05	.1	.1	.1	.27	.27	.27	
Department of Treasury:																
IRS																
Customs																
BATF																
Department of Labor	1.41	1.41	1.41	3.35	3.35	3.35	1.17	1.17	1.17	1.11	1.11	1.11	1.1	1.1	1.1	
Department of Agriculture	.6	.6	.6	.3	.3	.3	.3	.3	.3	.3	.3	.3	.3	.3	.3	
FDA																
ACTION	1.7	1.7	1.7	2.5	2.5	2.5	4.6	4.6	4.6	4.7	4.7	4.7	5.9	5.9	5.9	
TOTAL	410.3	410.3	458.8	370.8	370.8	403.4	198.1	198.1	315.5	204.0	204.0	112.4	224.2	224.2	218.1	

* Does not include ADAMHA block grants to states-Drug funds FY82 min$78/max $146; FY83 min$79/max$170; FY84 min$70/max$175.

Mr. **Rangel**. We also have been informed that the Customs Service has been asked to increase their responsibility and take a 2,000-slot cut in terms of manpower.

Dr. **Turner**. I discussed that issue with Mr. von Raab on Monday, and we are getting together Monday of next week to discuss that issue. After that, we may come talk with you regarding that, Congressman.

Mr. **Rangel**. One thing we ought to do off the record so that we don't appear to have these confrontations is that we are going to have to start working from the same sheets because there is no way in the world for us to come with such dramatically different conclusions.

Dr. **Turner**. As I said, my office provides a crosscut of all the Federal agencies involved in drug abuse issues, whether it is enforcement, international aspects, or whatever. I would be happy to share those with you.

Mr. **Rangel**. Suppose we get another chance to go around, Mr. Guarini, when we hear from Mr. Coughlin, who hasn't had a chance to inquire?

Mr. **Coughlin**. Thank you, Mr. Chairman.

Let me just say that, despite the fact that the questions and the testimony here elicit the thought that there is always room for improvement and there is always room for doing more, President Reagan and this administration have certainly raised the level of the drug abuse effort and the level of consciousness of drug abuse to a higher level than any administration that I have seen in my 16 years in the Congress. They are to be congratulated for that.

I think that the questions here should reflect that we always can do better and we always can do more, but the administration has indeed made this a high priority. I think that is important to note.

I think on the enforcement side, there is big money involved in this, and that makes it a very difficult thing to control. I would like to address a little bit the demand side, if I could, and ask you, Dr. Turner, to say something about your strategy for reduction of the demand side through drug abuse education and that kind of program.

Dr. **Turner**. Thank you, sir. As I mentioned before, this afternoon the President will sign the National Drug Abuse Prevention Education Week Proclamation, which will start tomorrow. In that connection, the Chemical People Program, which was developed by WQED out of Pittsburgh, will be carried by all public television stations with the exception of four, on the 2d and the 9th of this month. The first program, the scope of the problem, will air on November 2, and on November 9, the second program will deal with what communities can do about it.

This kind of effort integrates our prevention people with our treatment people, our enforcement people, our business community, our schools, the whole community. This is something that is being done by the private sector.

There are many other initiatives underway to educate the public on how to reduce drug abuse. The Pharmacists Against Drug Abuse Program is another example of how a professional organization within the United States accepted their responsibility to do something. That program was started in November of last year in the Greater Boston area, Maine, and New Hampshire. It went to all of New England and will go national this fall.

The efforts of the pediatrician are very important as we begin to look at the beginning end of drug abuse, and the pediatricians are educating themselves. They have a program against look-alike and act-alike drugs, to educate the young people and the parents, who come into their clinics.

The American Medical Association is starting a program that will distribute information through their offices to young people. Our schools have programs underway. We mentioned the Fairfax County Schools and the Department of Education. We have other programs underway, such as the National Association of Independent Insurers 10-year program to get the drug-impaired driver off the road.

We think that the programs that NIDA supports, the programs that ACTION supports—and those will be discussed tomorrow—the programs that the Department of Defense runs and the programs that professional organizations and service organizations in our country have will make a tremendous mark in reducing drug abuse.

The National Federation of Parents, the Mothers Against Drunk Drivers, the Lion's Club, the Rotary, the Junior League, the Women's Club; all of those are actively involved, as is the Elks Club.

When you gain that kind of support from the community level for our enforcement people, for our other professionals, I think it is one of the reasons we are seeing a continuous decrease in the beginning end of drug abuse.

Mr. COUGHLIN. I tend to agree with the chairman that somehow we have to get our baseline figures in agreement and somehow our staff working with your staff should do that, but at least according to the figures that I have been provided, the funding for treatment and prevention has gone from about $459 million in 1980 to $280 million in 1983. I guess that is a pretty significant decrease in the funding for that area.

Dr. TURNER. Those figures reflect the block grant money going back to the states. There have been some decreases in direct Federal funding. However, it does provide flexibility in how the money is used. I think the Congress could look at that block grant money to see how more flexibility could be obtained.

I notice that in fiscal year 1984, with the block grant money, the minimum that could be put to the drug area is $70 million but the maximum would be $175 million, so the flexibility is there, if the States choose to do it. However, I think Congress may want to look at some of those areas, where that drug money is going, and see if better ways exist to use that money.

That seems to me a great disparity between the minimum amount and the maximum amount, and that would skew those figures one way or the other. I don't know how much will actually be spent, but under the guidelines the minimum is $70 million and the maximum is $175 million.

Mr. COUGHLIN. The funding for demand reduction activities, as we understand it, has shrunk from about 46 percent of all the Federal expenditures to about 31 percent. Do you agree with that change in the mix?

Dr. TURNER. I think there has to be a realization that we are dealing with a national program and it must not be just a Federal program. Federal dollars are not the key. How much would it have cost the Federal Government to provide the prevention effort and concept that the Chemical People Program will bring? I contend it would cost millions of dollars. How much would it have cost the Federal Government to get the Lion's Club involved internationally?

We must realize that we are leaders of the Western World and that we have to be cognizant of what is going on in other countries. With the Lions Club we not only get the prevention efforts here, but we also affect programs in 157 other countries.

I would say that now we are looking at the bottom line. The bottom line is a national program, and I would contend to you that nationally we now are spending a lot more money in prevention than we have ever spent before in prevention and education; not just Federal dollars, but dollars from all-encompassing sources.

Mr. COUGHLIN. Let me just turn to one other question and then yield back to the chairman.

Have the Colombian authorities extradited any of their drug traffickers?

Dr. TURNER. I was just doublechecking with the gentleman from the DEA. We have one recent extradition, but that was of a U.S. citizen. We believe, and our Ambassador in Colombia believes, that when the documentation is presented, with the change of the mood in Colombia, that we can expect those extraditions to be processed.

There was an arrest order that went out. That person jumped and has not been found as of this time. But we think the extradition treaty will work. If the Congress will continue the scrutiny and keep the pressure on that end, we will keep the pressure on the other end. I think we can make it work.

Mr. COUGHLIN. Thank you, Mr. Chairman.

Mr. RANGEL. Dr. Turner, I want to recognize Mr. Towns from New York, but because we have a different language in describing what is going on, you would not contradict that there has been a 30-percent reduction in the amount of Federal dollars that are available to the States to treat those people who are abusing narcotics, would you?

Dr. TURNER. With the figures I have, I have not seen the percentage, but there has been a reduction. I would like for my person to get with yours, so we can get that straight. There has been a reduction in the prevention Federal efforts, yes.

Mr. RANGEL. So, while you are saying there is an increase in resources, what I am going to ask our staff to do is to coordinate the reductions by State that our State people are saying that they have in losing Federal dollars, both in law enforcement, rehabilitation, and prevention, and then we are going to compile the 50 States and present this to you. We hope that you would make a comparable effort.

I would like to recognize Mr. Towns and to ask him whether he could share with you some of the statistical data as relates to the

State of New York feeling the Federal presence in the area of rehabilitation and treatment.

Mr. Towns.

Mr. TOWNS. Thank you, Mr. Chairman.

I am happy that you raised that question because as I was listening to the information that we received and then knowing the terms of the facts of the matter in New York State, I was just shocked by the numbers.

From 1980 to 1981, we were funded at the tune of $31.6 million. In 1981 and 1982, we were funded at the tune of $28.9 million. In 1982 and 1983, we were funded at the tune of $24.5 million. In 1983 and 1984, we are down to $14.8 million. That is a 50-percent cut, more than a 50-percent cut, and to listen to the fact that we are being funded at the same level or above is very shocking.

The people in New York State, for some reason or another, are being shortchanged. I haven't seen the numbers across all the other States, but if it is anything like New York State, then I would have to disagree with your figures right away.

Dr. TURNER. Congressman, I don't have the figures from New York State. I think Dr. Pollin may have those figures when he testifies tomorrow. They have it broken down into States, where the block grant money goes in each State. I don't have that figure.

All I said was that if you look at the minimum amount of the block grant money that could be used in drug abuse education, the minimum amount for all the money out there would be $70 million, whereas if you look at the maximum, that can be $175 million. I think there is a great deal of disparity between those two numbers. That is the reason I was suggesting that the committee look into those two.

Mr. RANGEL. If the gentleman would yield?

Mr. TOWNS. I will yield to the chairman, yes.

Mr. RANGEL. It is my understanding that once you have the block grants, that it is a State official who determines whether it is going to be used for mental health or whether it is going to be used for alcohol abuse or whether it is going to be used for narcotic abuse.

So, when you say all of it could be used for narcotic abuse, I don't think anyone is taking issue with you. That is assuming that the constituency for mental health and alcohol abuse disappears, isn't it?

Dr. TURNER. I believe the guidelines on that, they may have changed, but the guidelines were that 35 percent would be for drug rehabilitation, 35 percent for alcohol rehabilitation, with 20 percent for prevention and 10 percent discretionary money. This is the way that the Congress put the strings on that. I have no control over that.

I think we also have to recognize that those treatment facilities that deal with it, there is a combination of both of those drugs used in many cases, and some States are using the 20 percent or the 10 percent in the area where other States are using it differently. I would like to look at the figures of the Congressman from New York and discuss them.

Mr. **Rangel**. But his figures, my figures, your figures, there are less Federal dollars available no matter what they want to do. Is that correct?

Dr. **Turner**. In the area of prevention, yes.

Mr. **Rangel**. OK.

Mr. Towns.

Mr. **Towns**. Thank you, Mr. Chairman.

On the line of questioning there, when you mentioned you have no input in terms of the type of treatment programs that a State gets involved in, do you mean to say in your research, if a program wanted to put all the money in methadone maintenance, that would be allowed?

Dr. **Turner**. Yes, sir. As I stated when I visited with the people in New York at Congressman Rangel's request, if a State chooses to use all of their money for methadone maintenance, that is the choice of the State. We have a responsibility to develop new methodologies, to develop new chemical entities that can be used in the treatment of opiates and other addictive disorders.

We have two now. Naltrexone, according to the latest information from the FDA, will be available at the end of December or the first of January, which is a narcotic antagonist. Then there is a product that is used, I think Dr. Primm is using it in New York, which is LAAM. LAAM requires the person to visit the facility only three times a week instead of on a daily basis. Naltrexone can be used to directly counter the effects of the opiates.

My position was that those are available. We will continue to make other issues or other therapeutics available, but if the State chooses to use methadone, it is certainly the right of the State.

Mr. **Towns**. The reason I am raising the question is that in your research, how do you get this information out to the various areas? I am concerned about the fact that an area might be involved in treating addicts and maybe there is something that is much more effective that they have no knowledge of. How do you get this information out to them?

Dr. **Turner**. Congressman, there are several ways. You have a very prominent treatment person in New York, Dr. Beny Primm. Dr. Primm has constant contact with the National Institute on Drug Abuse and knows of their evaluations. There is also the committee on the problems of drug dependency that has an annual meeting where all the people involved in research on evaluating new therapeutic regimes get together and discuss their research findings.

This is the way in which the LAAM has been made more available. This is the way in which Naltrexone has been made more available. NIDA will continue to participate in those meetings. I think clonidine is another example of a product being evaluated with those groups. Dr. Pollin can probably give you more information on that tomorrow.

There is another product called buprenorphine, which has some therapeutic use. NIDA is assisting drug companies and developing those, and, with the Orphan Drug Act, we have a new tool to get more of those on the market. That is exactly what we are pushing, to get that information disseminated.

Mr. Towns. I understand. I think you are really going right to my question. The question I am trying to get to is if a program is involved in methadone maintenance, drug free, whatever the approach might be and it is a third-party situation and now they would like to move off into another area, what support comes forth? I don't know.

I don't quite understand how they are able to get additional support to move off into another area. I find it very hard to see how they can move off into a different area when within a period of about 4 years they received a 50-percent cut. How can they go into a new treatment modality because it requires space, it requires a lot of start-up things, and I want to know what kind of support would they get from you?

Dr. Turner. I think we have to look at where the research goes as to which modality should be used, but I don't think we should assume that it is solely the Federal Government's responsibility to provide treatment facilities. I think we have a responsibility to see if third-party payments can't be made available.

I think we have responsibilities to work with the employee assistance programs, where appropriate, and work with the States. I think the States have to contribute. We all know that crime is associated with drugs. I think the States must make a decision whether it is better to provide treatment money or incarcerate the individual.

I think those are the issues that have to be discussed. With Congressman Rangel's concurrence I have met a couple of times with the people from New York to discuss the issues, just as you were doing. I think we will continue to do our research and continue to make that information available.

I mentioned once before that alternative treatment is available. I don't know what the methadone maintenance cost per day is in New York but suppose it is, say, for a round figure, $10 a day. If you choose to go to LAAM and you don't have to go in 7 days a week, there is a significant cost reduction there. It is not a 50-percent reduction but it is approaching it. I think these are the things that we need to identify at the Federal level to make the States more efficient in using the money they have.

Mr. Towns. Let me just say that the State of New York seems to have a real commitment because they have gone from $61.5 million to $80.4 in 1982–83, so the State seems to be willing to participate. I am hoping that we see the same thing coming from the Federal Government.

Mr. Chairman, I yield.

Mr. Rangel. Thank you.

I want to recognize Mr. Guarini but at this point, Dr. Turner, is it at all possible for you to assign a staff member to work with our staff just to make certain that when we have these meetings that we are dealing from the same statistical base? We are talking about billions of dollars.

Our staff now is preparing an analysis based on information given to us by the States. When we get the 50 together, that is supposed to be our national picture, and we have to give it to you. But we are not here, as was pointed out by Mr. Coughlin, to have a contest because when we go back to our districts we are the Federal

Government so we can't share with them any problem we are having with you. We represent the Federal Government.

So, is it at all possible for you to assign a person who has knowledge of the statistical data, especially as relates to budget, to work with us so that if we have differences, they are not just one of numbers or method in trying to find out what is available?

Dr. TURNER. Yes, sir. That will be no problem.

Mr. RANGEL. That is good. We will get together with you as soon as possible and see how we can work it out.

Mr. Guarini.

Mr. GUARINI. Dr. Turner, I would appreciate your views on just a couple of points and matters, briefly.

Legitimate business, such as bankers and investment advisers, help to wash the money and work with the syndicates in our society. That is how they can move billions of dollars and reinvest it. There is a whole banking scheme that is set up in various banks throughout our country.

I am wondering whether or not you feel that these legitimate business operators who cooperate and work with the dealers and pushers should be given the same kind of criminal sanctions that we have against the syndicates themselves?

I think what the history has shown is that they have gotten large fines but they haven't been given the prison sentences. I am asking if you equate these two on the same level.

Dr. TURNER. Yes; I equate them on the same level.

Mr. GUARINI. And you would support legislation that would equate them on the same level?

Dr. TURNER. I think, as Mr. Leonard has mentioned, some have gone to jail. I think that the Congress and the American people are demanding that we treat those as criminals.

Mr. GUARINI. They should go to jail just as long as anybody that pushes or deals?

Dr. TURNER. Nothing appalls me more than a person that is facilitating the transfer of the money from one place to the other to participate in illegal drug traffic and then that person walking. I don't like that.

Mr. GUARINI. I agree with you. I thank you for your view.

In regard to your attitude toward the Rangel-Gilman bill, which relates to withdrawing foreign aid from countries that do not cooperate with our officials in regard to the eradication of drugs, since this is your first priority and we do have a national strategy, what is your view concerning the Rangel bill?

Dr. TURNER. I think I mentioned that before. I believe that is H.R. 2992 and that we have no opposition to section 506, which deals with what you are talking about.

Mr. GUARINI. Do you support it actively?

Dr. TURNER. I haven't actively supported it, but I have no reason not to support it.

Mr. GUARINI. Is there any reason why you would not support the bill?

Dr. TURNER. No; there is no reason. I just said that I would support that.

Mr. GUARINI. I am talking about strategy, and I would like to see where you are coming from.

Dr. **Turner**. I just said that our position was that we would support section 506 in H.R. 2992.

Mr. **Guarini**. Would you help and aid in the passage of it?

Dr. **Turner**. If called upon.

Mr. **Guarini**. Let me ask you this. What is your attitude toward users? How should we treat users? Should we wait until they mug, rob, murder, et cetera before we impose any criminal sanctions against them?

Dr. **Turner**. I think we have to look at the spectrum of users and we have to start with a strong education and prevention program, to try to prevent them from using. Once they become users, I think society has a responsibility and obligation to tell them that we are not going to tolerate that behavior anymore.

I think once they get to the point where they are involved in the criminal activity, they should either be provided treatment if treatment is available, or if they don't want to go into treatment, they should be treated as a criminal. I have no problem with that at all.

Mr. **Guarini**. We lock drunks up because they are drunk. Should we lock users up because they use?

Dr. **Turner**. Well, we lock drunks up because they are intoxicated and impaired at the time.

Mr. **Guarini**. And that they are dangerous to society.

Dr. **Turner**. And that they are dangerous to society. I think society is beginning to take a position that much stronger initiatives are needed. If you look at the roadblocks here, I think we need to get the impaired drivers off the road and I think we need to structure our society a little bit better.

Mr. **Guarini**. Do you think that we should increase sanctions against users of drugs and begin to make examples of people instead of national heroes on television?

Dr. **Turner**. I think we need to deglamorize drugs on television. We are very strong on that. There is one thing that I would like to refer to, which is a recent report from the field organization in California, in San Francisco, which I think is rather significant.

In the community in San Francisco 54 percent of those people polled favored stronger drug law enforcement efforts, particularly involving the beginning use of marijuana. So, when you get that kind of change occurring, I think society is beginning to change and beginning to demand stronger efforts.

Mr. **Guarini**. So some efforts should be made against users?

Dr. **Turner**. I think so. I think the strategy that the chief of police here in Washington has pursued is beginning to be effective.

Mr. **Guarini**. I share your view. Quickly, just two short points.

Do you feel that it is your responsibility to initiate cooperation with the State and local authorities? I said to initiate. I asked you to answer it.

Dr. **Turner**. Yes, sir; that is one of the reasons we made certain that my deputy was a member of the local enforcement community with many years of experience. I think if anyone has had enough experience to know how those communications and the coordination could be accelerated, Mr. Leonard does.

Mr. **Guarini**. In other words, you feel that it is your responsibility as special assistant to the President to see that we should call together local authorities, local sheriffs, local chiefs of police, educate them, share information, and cooperate together.

Dr. TURNER. I am a very strong believer in coordination. I am a very strong believer in training. I am a very strong believer that the local authorities play a very vital role in our enforcement. The DEA can be the umbrella and give technical assistance, but the local police are the ones where the action is overall in this country. As I said, I was out in California recently meeting with the local authorities, and in the States of Oregon and Washington.

Mr. GUARINI. Well, I am just asking——

Dr. TURNER. Yes, I believe——

Mr. GUARINI. To pinpoint the question, do you believe that it is your responsibility to get everybody together as a national strategist?

Dr. TURNER. If there is a specific problem that has been observed, it is my responsibility to get them together. I have good relationships with the locals, and I continue to keep that relationship.

Mr. GUARINI. Therefore, we can, in the future, feel that you will be getting the local people together, that you will initiate, not just wait to cooperate?

Dr. TURNER. Well, there is a limited amount of my time that is available for that. I will do everything within the time constraints placed upon me. I will continue working with the locals.

Mr. GUARINI. If you have to structure your office differently, but I am asking if that is your responsibility?

Dr. TURNER. I accepted that responsibility some while ago. If I didn't mention it emphatically, it was so intended.

Mr. GUARINI. Last, do you feel it is your responsibility to eliminate any of the interstrife and overlapping and duplication of jurisdictions that exist between the various agencies that are fragmented in our drug effort? You know the agencies I am referring to, the DEA, et cetera.

Dr. TURNER. Yes, the agencies that you are referring to I think now are cooperating better than they have in the past history.

Mr. GUARINI. Is it your responsibility to——

Dr. TURNER. It is my responsibility to get them together to solve those problems.

Mr. GUARINI. Is it your responsibility to make recommendations if they don't get together?

Dr. TURNER. I have made recommendations when I thought they were needed. Yes, I have that responsibility, but I will tell you that as long as we have human beings involved, we will be able to go into any organization and find individuals who are disgruntled. We cannot solve that. We can all work together to make it better.

Mr. GUARINI. But we have to eliminate the jealousies, special turfs, special preserves that people carve out for themselves in our bureaucracy. I am just wondering whether or not it is your position that your job is to cull out any of this jealousy of jurisdiction and bureaucracy and overlapping, duplication?

Dr. TURNER. I think a certain amount of healthy competition is needed. I think there is a certain amount of overlapping that our American society has taught us is desirable. When that gets to the point that it is not desirable, I will intervene.

Mr. GUARINI. Isn't that a waste of funds when we overlap and duplicate?

Dr. TURNER. I think if you look at competition in the American society, some competition is healthy. I think we have good, healthy competition between some of the agencies. Unfortunately, some of the competition is interpreted as turf, friction, et cetera.

I said that when it gets to the point to where it needs to be addressed, I will be happy to address it. I try to deal with it at the policy level with the head of each agency and do not go down into the agency management. That is the reason I meet with the heads of the agencies on a regular basis and bring problems to their attention.

Mr. GUARINI. You haven't heard where agents with different departments would actually fight over who made the arrest so there is jealousy as to who gets credit for it?

Dr. TURNER. Yes, that happens. I can also give you examples where within a single office of a single agency there is that same kind of jealousy regarding who will get credit. Our philosophy is that we can do a lot as long as we are not concerned about which individual gets the credit.

Mr. GUARINI. Aren't we wasting our energies and our talents and our money when we have all this fragmented effort?

Dr. TURNER. I think we have better coordination now than we have had in many, many years. I think everyone will have to agree with that, but any fragmentation is a waste of effort.

Mr. GUARINI. But better is not best. What is the best that we could do? That is what I am trying to get to?

Dr. TURNER. That would probably be a dictatorship.

Mr. GUARINI. Of course, you want to exist with the situation that we have now, that you say that it is adequate and it is healthy. I submit to you that there are people who disagree with that.

Dr. TURNER. I am sure there are. That is the value of a democratic system, that we can get together and disagree, but if someone asks me what would be the ultimate, I guess that would be a dictator state. I don't think anyone here wants that.

Mr. GUARINI. No, we ask for efficiency and economy in government. I think that we are both coming from the same direction.

I appreciate your efforts. I know you have a very, very difficult job to do, Dr. Turner. What we are trying to do is work together in the spirit of getting to the bottom of this insidious disease that we have in our society. I think we both share the view that it is a terrible disease and something more effective should be done that hasn't been done in the past.

Dr. TURNER. I think working together we can do that. That is the reason that at every opportunity, when the chairman has asked me to do something, we try to do it and try to work together. We will continue working together because there is a certain amount of group dynamics involved. We need to keep involved in working with each other.

Mr. GUARINI. Thank you, Mr. Chairman.

Mr. RANGEL. In that spirit, Dr. Turner, let me say that, as you well know, members sought assignment to this committee. Our committee has members from the Ways and Means Committee, where we deal with international agreements and jurisdiction over the Caribbean Basin; members of the Judiciary, which deals with all of our Federal laws in this area; Appropriations; Foreign Affairs; Government Operations; Armed Forces; Veterans; Agriculture.

What we are trying to say is that we are tools to be used in this overall strategy and policy for the administration. By the same token, we have the responsibility for our colleagues to provide some type of oversight.

We think that by getting the liaison which you assured us that we would have, that we will be in a better position to analyze what is the Federal strategy because we don't want it to be that the local and State governments have to learn how to do more with less. But we do want to make certain that we—435 people—will be able to point out to State and local governments how they can better utilize the Federal resources that are available.

So, we will be joining you at the White House in proclaiming the National Drug Abuse Education Week and look forward to working with you and Mr. Leonard and the entire team.

Dr. TURNER. The feeling is mutual. Thank you for giving us this opportunity.

Mr. RANGEL. We will be meeting tomorrow at 9:30. I want to thank the members for their participation.

We stand adjourned.

[Whereupon, at 12 noon, the select committee was adjourned.]

[The following was received for the record:]

SUBMISSIONS FOR THE RECORD

U.S. HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON
NARCOTICS ABUSE AND CONTROL,
Washington, D.C., November 14, 1983.

CARLTON TURNER, Ph.D.,
Special Assistant to the President for Drug Abuse Policy,
The White House, Washington, D.C.

DEAR DR. TURNER: On behalf of the entire Select Committee, I want to thank you for appearing before the Committee on Tuesday, November 1, to testify and answer questions about the Administration's 1982 Federal drug strategy. The strong bipartisan participation in the hearing by our members demonstrates the depth of our concerns about Federal efforts to prevent and control drug abuse in our nation, and we appreciate your cooperation in coming before us to review the Administration's policies.

At the hearing, some confusion developed over the level of Federal expenditures for drug abuse treatment and prevention programs. There was also some disparity over data relating to drug abuse trends, particularly heroin and cocaine. As we agreed during the hearing, the Committee would appreciate it if you would assign a person from your office to work with Committee staff to establish a consensus on—or at least a common frame of reference for talking about—drug abuse statistics and Federal resources committed to drug abuse programs.

On Wednesday, November 2, the Select Committee continued its hearings to examine the Federal drug strategy. One of the witnesses who testified was Mr. Paul E. Robinson, Executive Secretary, City of Boston Coordinating Council on Drug Abuse, and Immediate Past Chairperson, National Association for City Drug and Alcohol Coordination, Inc. In both his written and his oral testimony, Mr. Robinson attributed to you statements that the Administration was only concerned about drug abuse in suburban communities, not inner cities. A copy of his written testimony is enclosed. The statement attributed to you appears on page nine. The transcript of our hearing is not available yet, but we will be happy to provide you with a copy of the relevant portion of Mr. Robinson's testimony. We would like to give you the opportunity to clarify or respond to the statements he says you made.

As a further follow-up to our hearing, we would appreciate your written responses to the enclosed questions.

Again, we thank you for your cooperation and look forward to your reply.

Sincerely,

CHARLES B. RANGEL,
Chairman.

THE WHITE HOUSE,
Washington, D.C., December 8, 1983.

Hon. CHARLES RANGEL,
U.S. House of Representatives, Chairman, Select Committee on Narcotics Abuse and Control, Washington, D.C.

DEAR CHAIRMAN RANGEL: Thank you for the opportunity to appear before the Select Committee on Narcotics Abuse and Control and to share the Administration's Federal drug strategy with you. I would like to confirm that Mr. Leonard delivered the completed transcript and my answers to the additional questions which you requested. I have just returned from travel overseas and will share my observations regarding Pakistan with you at your convenience.

In answer to your question regarding the statement which Mr. Paul E. Robinson of Boston attributed to me, my comment was not accurately reported and was certainly taken out of context. As you know, I am keenly interested in the narcotic addiction problem in our urban areas and the Strategy of this Administration clearly includes a major effort in reducing heroin use. However, the Strategy includes vigorous efforts in all areas of drug abuse. We have not limited our attention to only the problems of the inner cities, but must and have addressed the drug problems across the entire nation. Mr. Robinson's testimony reflects his primary interest in narcotic addiction problems in our cities.

Again, thank you for the opportunity to appear before you and I appreciate all the attention you continue to draw to the drug problem around country. I look forward to working with you in the future and please do not hesitate to contact me if I can be of assistance.

Sincerely,

CARLTON E. TURNER, Ph.D.,
Special Assistant to the President for Drug Abuse Policy.

ADDITIONAL QUESTIONS FOR DR. TURNER

1. Congress included the requirement for a strategy council when it passed the Drug Abuse Office and Treatment Act of 1972 to assure the consideration of a broad range of views, both Federal and non-Federal, in the development of a national drug strategy. If a strategy council has not been established, how did the Reagan Administration obtain the views of non-Federal drug experts in formulating its drug strategy?

Answer. During the preparation of the 1982 Federal Strategy for the Prevention of Drug Abuse and Drug Trafficking we sought a wide range of advice and assistance. Initial discussions and input from the many Federal agencies with drug abuse responsibilities resulted in a draft report which was furnished to those agencies for comments and suggestions. Comments were solicited from a considerable number of experts and interested parties outside of the Federal government. A number of medical and research experts, 80 state and local law enforcement officials, and leaders in groups such as PRIDE, National Federation of Parents for Drug Free Youth, Dekalb Families in Action, National District Attorneys' Association, National Association of State Alcohol and Drug Abuse Directors (NASADAD) were included.

2. The 1982 Federal Strategy makes brief reference to the "high priority" needed in combating heroin and cocaine abuse, but includes no specific, strong response to these problems. Local initiative is stressed, but Federal funding support has been reduced. Statistics compiled by the Select Committee show a continuing rise in heroin and cocaine abuse in major cities around the country. In view of the tremendous financial and social cost of heroin and cocaine abuse, what do you feel should be done about these pressing problems?

Answer. The 1982 Federal Strategy reports: "Opiate abuse still causes serious problems in terms of criminality and personal suffering and the 1982 Strategy continues to recognize the need for a strong response to heroin. However, programs must also respond to the large numbers of people and families who are suffering the direct and indirect effects of other drugs of abuse, including marijuana and alcohol . . . The 1982 Strategy does not attempt to dictate from a national level the relative priorities for local responses to drug problems."

The Strategy's five elements constitute an appropriate response to the problems of drug abuse. Looking at the foreign sources, trafficking and transportation, and the effects of drug abuse, the Strategy includes efforts to reduce the availability of illicit drugs, specifically:

International efforts to stop foreign production of drugs as close to their source as possible; and

Drug law enforcement to reduce the availability of illicit drugs in the United States.

In the health-related aspects of drug abuse, the Strategy calls for:

Education and prevention efforts in a comprehensive, long-term campaign to discourage drug and alcohol use with the Federal government leadership, encouragement and support;

Continuing the evolution of successful drug treatment delivery services, with emphasis on encouraging the states to make their own decisions regarding the allocation of available funds; and

Promotion of research to develop and disseminate understandable information about drugs, for use by health care professionals, researchers, educators, and the public.

The Strategy also includes expansion of prevention programs for reducing drug and alcohol abuse in the Armed Forces.

3. What is your role in the budget process, and what might we expect in terms of resource allocations in fiscal 1985 for key drug abuse prevention agencies such as Customs, Coast Guard, DEA, INM and MIDA; for the Alcohol, Drug Abuse and Mental Health block grant; and for efforts such as NNBIS and the OCDE Task Forces including South Florida?

Answer. My role is to review the agency budget requests, to advise whether the budgets are consistent with the objectives of the Federal Strategy, and to seek appropriate changes, if necessary. My principal interests are the functions which are directly related to drug abuse. We are currently involved in the review process for the Fiscal Year 1985 budget and it would be inappropriate for me to discuss the probable results. The Fiscal Year 1985 budget will be submitted to the Congress in January 1984.

4. The Administration has not sought any additional funding for the NNBIS program in FY 1984? Will this decision have a negative impact on the ongoing responsibilities of the agencies involved in NNBIS, particularly the Coast Guard and the Customs Service? Please explain.

Answer. NNBIS is an example of seeking stronger drug law enforcement through more effective use of existing resources and, as called for in the Strategy, increased effectiveness in interdicting illegal drugs being smuggled by sea or air, through ports of entry or on land borders between ports of entry. In addition to increased effectiveness, additional resources have been committed in the form of military assistance and higher levels of commitment by the multi-purpose agencies, particularly the Coast Guard and the Customs Service. There is universal agreement that the intensity of coverage and overall effectiveness has improved significantly. The resource questions are being evaluated during the ongoing budget review and it is premature to comment on them.

5. Admiral Thompson of the Coast Guard, who is also the Vice President's on-site coordinator for the South Florida Task Force as well as the Southeast NNBIS coordinator, and Peter Gruden, the DEA Miami Regional Agent-in-Charge, testified at the Select Committee's recent hearing in West Palm Beach. Both of these officials claimed that the production of marijuana in Colombia and South America had decreased. Moreover, Mr. Gruden stated that there is a "reduced demand for marijuana in the U.S." contributing to a reduced supply. Both these statements are clearly contrary to what we saw during our study mission to South America and by what we see in our own districts concerning marijuana use. Do you support these statements? If so, what evidence do you have to support these claims?

Answer. There is agreement that Colombian marijuana production in 1982 was lower than expected for several reasons, including drought and government intervention. Both the Fall 1982 and Spring 1983 crops were well below normal and these are the crops which directly relate to the current supply of Colombian marijuana within the United States. However, DEA estimates the Fall 1983 crop will be considerably larger. The Fall 1983 crop is the crop that your delegation viewed during the recent visit.

It remains to be seen how much of the increased 1983 cultivation in Colombia will reach the United States. The Colombians have already seized 450 metric tons of this fall harvest, and we can expect further reductions in the potential supply due to additional seizures and other interdiction efforts.

Annual surveys of high school seniors reflect that the daily use of marijuana peaked in 1978 and has been steadily decreasing each year since then. Indications of reduced demand for marijuana in the U.S. reflect changing attitudes toward marijuana and the intense prevention effort directed at reducing youthful use. I expect this downward trend to continue, but use levels still are too high. The downward trend is encouraging and is a strong incentive to redouble our prevention efforts.

6. Our recent study mission to Latin America and the Caribbean found the cultivation of marijuana and the production of cocaine completely out of control. We also found no affirmative steps being taken by the governments of Peru, Bolivia, Colombia, and Jamaica to abate this activity; nor do we find any aggressive moves by our State Department to convince these nations to undertake effective eradication projects. What plans do the White House and President Reagan have to deal with these nations to accomplish a substantial reduction in their production of raw narcotic drugs?

Answer. The Administration has been aggressive on both the diplomatic and programs fronts. President Reagan has expressed his concerns to President Betancur, who in turn acknowledged this mutual priority in his discussions with your delegation. Vice President Bush, Secretary Shultz and Attorney General Smith have also furthered U.S. policy objectives by discussing narcotics control initiatives with leaders of source nations in South America.

The Department of State is generating steady progress on eradication. As you are aware, we were unable to initiate negotiations with Colombia on cannabis control until earlier this year, due to previous Congressional prohibitions on paraquat spraying programs overseas and the need to do an environmental impact statement. However, we are increasingly optimistic about the prospects for an enhanced control program in Colombia. While the pace has been slow in Peru, there has been eradication in 1983 and the capability for eradication has been increased. We are expecting 1984 eradication to expand to over 4,000 hectares and we plan to support an expansion of the program into another coca producing area of Peru. The State Department recently signed, after extensive negotiations, four narcotics control agreements with Bolivia. A 165-man special narcotics task force will soon establish a police and security presence in the Chapare which will allow simultaneous coca control activities. These and other activities by our Department of State and the Governments in the source countries are improving the prospects of an effective control program.

7. The availability of cocaine appears to be quite high around the nation. The Drug Enforcement Administration recently announced that the price of cocaine has fallen sharply around the country. What plans does the administration have to combat this threat?

Answer. Cocaine is an extremely dangerous drug and the Federal strategy includes a strong law enforcement response to reducing cocaine abuse. The number of users is high, the methods of use in vogue are extremely dangerous, and the illegal profits are a lure. However, while it is clearly a consideration, the apparent short-term availability is not the best indicator of the extent of the problem. There are several potential contributing factors, including the likelihood of undetected large imports, a reduction in the number of users, and a softening of demand because of growing awareness of the health dangers. Some of the likely reasons are good, some are bad; all would support the stated indicators. We will continue to track and evaluate the situation. Also, we are pursuing vigorous law enforcement, international control effort, and education and prevention efforts, as called for in the Strategy.

8. At Select Committee hearing in New York, Washington, D.C. and in Florida, drug abuse treatment and prevention services administrators voiced strong criticisms of the Administration's drug abuse prevention and treatment strategy, as well as Federal funding in those areas. A summary of these criticisms would be that the abrupt reductions in Federal funding for the Alcohol, Drug Abuse and Mental Health Block Grant have placed a tremendous burden on state and local governments. The result has been limited resources to treat and address a growing substance abuser population. These critics also claim the Federal Strategy emphasizes law enforcement over treatment and prevention efforts and point to a growing imbalance in resources committed to supply control as compared to demand reduction as evidence of this shift in emphasis. They claim that NIDA's role as our nation's lead agency to assure quality drug abuse services has been emasculated. Could you respond to these criticisms?

Answer. The Strategy includes a comprehensive prevention and treatment program including integrating drug and alcohol treatment services into the general health care system and encouraging private industry, religious groups, private organizations, and State agencies to work together to support prevention programs.

Regarding Federal funding, the change to block grant funding was made at the end of FY 1981. However, funds from previous years continued to be expended through FY 1983. NIDA expended $97 million in treatment funds during FY 1982 and $3.5 million in FY 1983. During this period, the block grants began, with the states having flexiblity in their use which allows transfer from one program to another (e.g. between mental health and substance abuse, and among alcohol and drug abuse programs within the substance abuse portion of a state's allotment). NIDA advises that the range of block grant funding for drug abuse programs is as follows:

FY 1982 allocation—minimum $78 million/maximum $146 million.

FY 1983 allocation—minimum $79 million/maximum $170 million.

FY 1984 allocation—minimum $70 million/maximum $175 million.

NIDA also advises that the Federal government has never been the major direct supporter of drug abuse treatment and prevention services in the nation. State and local governments, other public welfare programs, insurance, and client fees have always made up the bulk of the total funding. During the period between 1977 and 1980, when the Federal government's funding for drug abuse treatment and prevention programs were at their highest levels, they amounted to only between 33 to 38 percent of the total funds spent. Therefore, it is somewhat misleading to suggest that reductions in funding levels for drug abuse services under the block grant program are equivalent reductions in overall funding levels.

Health-related drug abuse programs run by state and local governments are an integral part of the national program and their spending better reflects the delivery of treatment and prevention services. The National Association of State Alcohol and Drug Abuser Directors reported a Survey of State Resources (March 1983) for substance abuse program expenditures in FY 1983 which were:

	In millions
Treatment monies spent by states	$993
Prevention monies spent by states	122
Total reported	1,115

While these amounts include block grant funds and the alcoholism programs, they demonstrate that the delivery systems at the state level are a very important part of the national effort to prevent drug and alcohol abuse.

Regarding the alleged lack of balance, the Federal Strategy does not intend to emphasize law enforcement over treatment and prevention efforts, but calls for a comprehensive effort in all areas. NIDA has an important role and continues to perform it in an effective manner.

9. Do you feel that a Federal court injunction of DEA's domestic marijuana eradication program utilizing paraquat has irreparably impaired our efforts to convince South American nations to employ the use of paraquat in their eradication efforts? What plans does the Administration have to use paraquat or other herbicides to eradicate marijuana in the future?

Answer. The answer to the first part of the question is no. As you know, the injunction has been lifted without judgment and the government has agreed to complete an environmental impact statement. The 1983 growing season in the United States has ended and there is no immediate effect. However, we are planning a major eradication program for the 1984 growing season and will use all available techniques to eradicate marijuana production. During this past season, it was reported to me that California used napalm and Arkansas used a dye/odorant with success. We intend to make every effort to focus attention on destroying marijuana as close to its source as possible.

10. DEA allocated $2.4 million to its domestic marijuana eradication program in 1983 and has budgeted $2.5 million for the program in FY 1984. Is this a sufficient level of resources to support an effective national eradication program and to fulfill our international obligations to eradicate the illicit cultivation of marijuana in this country?

Answer. Yes. The DEA program is appropriate in meeting their direct responsibility which is to provide leadership and encouragement of a national effort. In addition to the DEA, the Forest Service, the Bureau of Land Management, the U.S. Armed Forces (including the National Guard), and other available Federal law enforcement personnel also contribute to the effort. The Federal effort is combined with a major effort by state and local law enforcement officers in every state for a national eradication program. DEA continues to do an excellent job of providing leadership and training.

11. At the Committee's recent hearing in West Palm Beach, state and local law enforcement officials were highly critical of the failure of Federal law enforcement personnel in charge of the task force operation to consult with them over the course of the task force operation. Close cooperation between state/local law enforcement and Federal enforcement is essential to the implementation of a successful drug enforcement policy. Could you comment on the apparent failure of the South Florida Task Force to establish a close working relationship with local policy?

Answer. I must disagree with the allegation of "apparent failure." Improving cooperation and coordination among Federal, state and local law enforcement agencies is a specific initiative in the Federal Strategy, and the South Florida Task Force is an excellent example of the progress made in cooperative efforts. There have been numerous favorable reports of the joint efforts and the working relationships established between the South Florida Task Force and local police. Since its inception, the task force has been in continuous contact with key local authorities. The Florida Department of Law Enforcement has accepted the invitation to participate in the Southeast Regional NNBIS Center. The NNBIS Regional Center has continued to maintain contact with the group, Miami Citizens Against Crime. The Southeast Regional Coordinator and Deputy Coordinator have traveled extensively to participate in the area Law Enforcement Coordination Committees (LECCs).

12. The Senate Appropriations Committee has added a provision to the Treasury appropriation bill that would authorize Customs to undertake drug investigations in certain cases, contrary to Reorganization Plan No. 2 of 1973. What is the Administration's position on this delegation of drug investigation authority to Customs?

Answer. The current law is adequate. Under existing legislation, the Attorney General authorized Customs officers assigned to the South Florida Task Force to conduct intelligence, investigative, and other law enforcement activities which are vested by law in the Attorney General. DEA and Customs have been working toward increasing joint operations between the two agencies to provide enhanced coordination of interdiction efforts. I believe that it is most effective to have mutual agreement between the two agencies, under existing law, regarding the investigation of drug offenses by the Customs Service.

13. The costs of drug abuse have been estimated at $100 billion annually, a staggering sum. A large portion of this cost results from crime associated with heroin abuse and the impact of heroin abusers on the criminal justice, health care and social services systems in our country. Numerous studies document the efficacy of treatment in reducing crime by heroin addicts. Why isn't the Federal government spending more, instead of less, money to treat heroin addicts?

Answer. The answer to question 8 responds to the question of Federal funding in some detail. The Strategy follows the logic of funding local service delivery through the state block grants so that the local officials can decide how the funding can best meet the specific needs of that community. Where heroin is the drug of highest concern, state and local authorities can make appropriate resource allocations.

14. In the first years of the Reagan Administration, funding for drug abuse research by NIDA was cut drastically. Even with the increases supported for FY 1983 and FY 1984, research funds for NIDA in 1984 are at about the same level as the funds available in 1980. Why has this Administration not given drug abuse research a higher budgetary priority?

Answer. Research in the area of drug and alcohol abuse is a key element of the Federal Strategy. The Drug Abuse Policy Office has worked to increase the attention to research in drug abuse, and in the closely related area of alcohol abuse. The increase requested in the President's budget for FY 1984 reflected this interest: NIDA's research budget was increased by 18%, or from $47.6 million to $56.2 million, and NIAAA's research budget was increased by 36%, or from $33.2 million to $45.4 million. Both of these increases were considerably higher than the general increases in the Federal budget, and higher than increases in biomedical research budgets in particular. However, the House of Representatives reduced both of these requests. The final bill reported out of conference partially maintained these reductions, resulting in an overall 20 percent reduction in the requested increase. I will again support a strong research effort in the FY 1985 budget.

PREPARED STATEMENT BY CHAIRMAN CHARLES B. RANGEL, SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

Good morning, ladies and gentlemen. This morning the Select Committee continues its review of the Reagan Administration's drug policies. We are pleased to have as our sole witness today Dr. Carlton Turner, the President's Special Assistant for Drug Abuse Policy, who will outline the Administration's 1982 Federal Strategy for Prevention of Drug Abuse and Drug Trafficking and dicuss the role of the White House Drug Abuse Policy Office in developing and implementing this strategy.

For the past several months, the Select Committee has conducted an extensive investigation of the drug abuse problems confronting our nation. Through public hearings, meetings with government and private officials both here and abroad, and onsite inspections or narcotics growing areas, we have attempted to look at all aspects of this problem. What we have seen and heard has been very disturbing.

Heroin continues to flood the northeast region of the country and indicators of heroin abuse have jumped dramatically in New York and other northeast cities. Increased heroin activity is not confined to that area, however, as Los Angeles, Detroit, San Antonio and other cities are now reporting sharp increases in heroin abuse and trafficking activity.

The availability of cocaine is greater than ever before, and the glut of cocaine on the market is driving prices downward.

Treatment programs are operating at or above 10 percent capacity, the demand for their services fueled by the readily available supplies of illicit drugs. Despite the increasing need for treatment and prevention services, Federal budget cuts are forcing reductions in these vitally needed programs.

State and local criminal justice systems—police, courts and prisons—are staggering under the burden of drug-related crime. Drug trafficking in some parts of our major urban centers proceeds unchecked.

Federal law-enforcement officials who testified before the Committee in South Florida recently conceded that the South Florida Task Force on Crime is not achieving an appreciable reduction in the flow of illicit drugs through that region of the country.

Illicit domestic marihuana production is a major and growing industry. Federal efforts to control this activity are inadequate to the task.

In Colombia, Peru, Bolivia and Jamaica, where the Select Committee visited in August, illicit cultivation of coca and marihuana is out of control. The situation is compounded by our Government's failure to put into place a bold international narcotics control policy.

In short, we appear to be losing the battle against drug abuse on nearly all fronts.

We welcome Dr. Turner here today and look forward to the opportunity to discuss with him how the Federal Government can provide effective leadership in meeting these grave national problems.

OPENING STATEMENT BY HON. BENJAMIN GILMAN AT THE NARCOTICS SELECT COMMITTEE HEARING ON THE FEDERAL STRATEGY FOR DRUG ABUSE TREATMENT, PREVENTION, AND RESEARCH

Thank you, Mr. Chairman. I am delighted to join with my colleagues this morning in welcoming Dr. Carlton Turner, as we continue to review the Federal Drug Strategy. We have been involved in an ongoing review of this Strategy for some time, and today we will be concentrating on some of the more critical aspects of that Strategy: treatment, prevention and research. No other aspect of the drug policy is more important, because despite all of our efforts to halt the supply of illegal drugs, illicit drug availability continues at totally unacceptable levels.

We are most pleased to have you with us this morning, Dr. Turner. We know of your strong commitment to the success of the Federal Strategy, and as the President's designated coordinator of our drug abuse efforts, I am sure that you will be able to provide us with the answers we need to ensure that our policies are effective and are targeted in a direction where they can do the most good.

Our Select Committee is interested in learning from you just how the Federal drug Strategy was developed and what steps you are taking to coordinate the efforts of this Government to halt the demand for and supply of illicit drugs.

Of equal importance, we would also like to know the extent that the Federal Government is providing funds and technical assistance to State and local governments in their efforts to combat drug abuse.

The Alcohol, Drug Abuse and Mental Health Block Grant has been in existence for two years. We are interested in learning its effectiveness in meeting the pressing needs of State and local governments.

Dr. Turner, there is no question that the use of marihuana, cocaine, alcohol and other dangerous drugs by our school age children is a major cause for concern, and parent groups are an important ingredient in any approach to develop a comprehensive, coordinated Federal drug strategy. However, in my view, the Federal Government needs to intensify its efforts to combat drug trafficking and drug abuse if we are to succeed in winning this deadly "war". In this regard, we look forward to hearing your testimony and we want to welcome you before our Committee.

STATEMENT OF CARLTON E. TURNER, PH.D., SPECIAL ASSISTANT TO THE PRESIDENT FOR DRUG ABUSE POLICY, THE WHITE HOUSE, ON 1982 FEDERAL STRATEGY FOR PREVENTION OF DRUG ABUSE AND DRUG TRAFFICKING, HEALTH RELATED ISSUES

Mr. Chairman, and distinguished Members of the Select Committee on Narcotics Abuse and Control, I am pleased to have the opportunity to appear before you today to discuss the health-related aspects of the 1982 Federal Strategy for the Prevention of Drug Abuse and Drug Trafficking.

In March 1981, President Reagan identified drug abuse as "one of the gravest problems facing us" and embarked on a vigorous program to help us as individuals and as a society overcome the problems associated with drug abuse. The 1982 Federal Strategy for Prevention of Drug Abuse and Drug Trafficking, which was released on October 5, 1982, is designed to provide direction to the national effort against drug abuse. The 1982 Strategy endorses international initiatives and vigorous law enforcement to reduce the availability of illicit drugs. Simultaneously, major health initiatives are being undertaken to reduce the abuse of drugs, including alcohol, and to prevent drug abuse in future generations of Americans.

The President has assigned a high priority to the drug abuse program and charged two Cabinet Councils with program responsibilities. I am a Special Assistant to the President and, as indicated by Executive Order 12368, I provide drug abuse policy advice to the President and coordinate and oversee the drug abuse functions of the Federal agencies.

The Cabinet Council on Human Resources is responsible for overseeing the implementation of the health-related aspects of the 1982 Federal Strategy, published in October 1982. I chair a Working Group on Drug Abuse Health Issues, under this Cabinet Council. I have established five task forces to assist and report on the implementation of that. The Working Group Task Forces on Education and Prevention, Detoxification and Treatment, Research, International Cooperation, and Drug Abuse in the Armed Forces have contributed to an implementation status report which will be completed within the next few weeks and furnished to the members of the Cabinet Council on Human Resources.

Participants in the task forces include the Departments of Defense, Education, Health and Human Services, Justice, Labor, State and Transportation. Independent agencies include ACTION, the Office of Science and Technology Policy, the United States Information Agency, and the Veterans Administration.

The consolidated report will summarize the task force efforts and contain recommendations for the consideration of the Cabinet Council. We will use the report as a basic reference in preparing the 1984 Strategy in the fight against drug abuse. When the report is completed, I will provide it to the Committee, and I will appreciate your counsel.

In discussing the health-related aspects of the drug program today, it is important to recognize that the law enforcement agencies have an important role in preventing drug abuse in the United States. Our law enforcement agencies are respected members of our communities, have credibility regarding their knowledge of the effects of illegal drugs, and are role-models for many of our young people. Therefore, the many thousands of law enforcement officers, Federal, State and local, can and do play a special part in the prevention of drug abuse in this society. The Drug Enforcement Administration (DEA) and the U.S. Customs Service are actively pursuing this important prevention role. The Federal Bureau of Investigation (FBI) and the Office of Juvenile Justice and Delinquency Prevention are also contributing.

We must emphasize however that drug abuse is not just a Federal problem. It is a national problem and must be the target of a national program. In the past, it often seemed that blaming the Federal government was a way in which you solved the problem. Unfortunately, this created a form of denial of individual and community responsibility and provided an excuse for inaction. Fortunately, times have changed.

All across the United States, our citizens, community organizations, and businesses have recognized that they can make a difference and are enthusiastically entering the battle against drug and alcohol abuse. Therefore, our national effort is characterized by a high level of commitment, innovation and cooperation throughout the public and private sectors. Programs have been strengthened, aligned, and realigned to address each aspect of the drug abuse problem and to ensure responsiveness to local priorities and needs.

The highlights of the task force reports will give you a good idea of the program.

EDUCATION AND PREVENTION

Today, education and prevention are in the hands of parent and community groups, peers, school officials and health care professionals, those closest to the user and potential user and therefore who can have the greatest impact on drug and alcohol abuse. The President and Mrs. Reagan's leadership and involvement have been outstanding. Federal, state and local officials, and concerned citizens from every segment of society are actively involved in this national effort.

Organized parent groups, working to promote an environment in which children are discouraged from using drugs and alcohol, have grown from approximately 800 to about 4,000.

Major organizational efforts to develop and coordinate statewide prevention efforts are well underway. Fourteen states are now organized or planning organization.

The Congressional Families for Drug Free Youth has been established to provide leadership to education and prevention efforts in the Congressional Districts.

On October 3, 1982, the Secretary of the Department of Health and Human Services announced a national Initiative on Teenage Alcohol Abuse which taps the potential of voluntary citizen efforts and others.

The Department of Education has developed and maintained alcohol and drug abuse prevention programs in over 4,500 school-communities.

DEA is providing speakers, publications and technical assistance to community and parent groups.

The Occupational Safety and Health Administration (OSHA) has implemented innovative cooperative programs which recognize the important role that employers and employees have in ensuring their own safe and healthful working conditions.

The Administration has embarked upon a comprehensive, community-based program to combat alcohol-related traffic fatalities. Major initiatives include the establishment of the Presidential Commission on Drunk Driving; a massive national public information, law enforcement and citizen action effort; and the development of programs for teenagers in each state.

The involvement and commitment of private sector and service organizations in the education and prevention effort is significant. Selected examples include:

Weekly Reader survey of children's attitudes on drugs and alcohol, sponsored by Xerox Education Publications;

Drug awareness comic books sponsored by DC Comics, Inc., The Keebler Company, the National Soft Drink Association, IBM and the National Federation of Parents for Drug Free Youth;

"Pharmacists Against Drug Abuse," sponsored by McNeil Pharmaceutical;

"Team Up Against Drugs," sponsored by the professional sports associations;

Steering Committee on Prescription Drug Abuse, sponsored by the American Medical Association;

Program against look-alike drugs, sponsored by the American Academy of Pediatrics;

Lions' War Against Drugs, sponsored by the International Association of Lions Clubs;

"The Chemical People" campaign, which will be aired on the PBS stations across the country, produced by WQED (PBS) in Pittsburgh and sponsored by a new National Coalition for the Prevention of Drug and Alcohol Abuse, representing 35 organizations and 15 million members and volunteers;

"Don't Be A Dope" campaign, sponsored by NBC; and

A teen-year impaired driving prevention campaign, sponsored by the National Association of Independent Insurers.

The national prevention effort is beginning to pay dividends. Although drug and alcohol abuse levels remain high, the trend is down instead of up.

The National Survey on Drug Abuse reports that, between 1979 and 1982, the number of Americans who were current users of marijuana decreased by 11 percent, hallucinogens by 55 percent, cocaine by 5 percent and alcohol by 7 percent.

The decreasing use of introductory drugs by young people is especially encouraging. Between 1979 and 1982, approximately 1.9 million young people stopped using marijuana and 2.4 million stopped using alcohol on a regular basis. The primary reason was increased awareness of the health risks posed by drug use.

In 1978, daily marijuana use by high school seniors peaked at 11 percent, or one in nine. In 1982, daily use had dropped to 6.3 percent, or one in 16. Perceived harmfulness has risen among high school seniors, as well as a perception of peer and parent disapproval.

The national total of alcohol-related accidents during the 1982 Holiday Season declined by 25 percent compared to 1981. Nationally, traffic deaths dropped from 49,945 in 1981 to 43,718 in 1982.

With the active involvement of parents and other concerned citizens, these decreasing trends are expected to continue. The priority for 1983–1984 is to build upon the solid foundation established in 1981–1982. The long-range objective is to eliminate drug and alcohol abuse in future generations of Americans.

DETOXIFICATION AND TREATMENT

The 1982 Federal Strategy recognizes that those Americans dependent on drugs and alcohol need treatment and professional assistance to free themselves of abuse problems and rebuild productive lives. The Federal government is assisting efforts to achieve more effective use of resources within the existing national treatment network, including the development of treatment programs which are more responsive to local priorities and the specific needs of a heterogeneous population with drug and alcohol abuse problems.

States gained more flexibility to determine specific treatment needs and respond accordingly in 1982 when the Federal share of treatment support was incorporated in the Alcohol, Drug Abuse and Mental Health Services (ADMS) block grants.

The ADMS block grant program and technical assistance by the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) are facilitating integration of drug and alcohol services into the general health care system for more effective and efficient treatment.

State and private treatment programs are being encouraged and assisted in making the appropriate provisions for counseling and medical services which meet the special needs of young people with drug, alcohol and related programs.

The Office of Juvenile Justice and Delinquency Prevention is integrating drug and alcohol prevention and treatment into the juvenile justice system.

The Department of Education has trained 4,500 teachers to identify and refer drug and alcohol abusing youth to early intervention programs.

The National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) are conducting feasibility studies to determine if certain types of traditional service delivery can be modified to be less expensive and remain effective.

During 1982, 74 Veterans Administration (VA) medical centers contracted for non-VA halfway house drug and alcohol treatment to provide more efficient programs.

NIDA has completed a comprehensive study which will improve the quality of existing opiate detoxification treatment programs.

NIDA continues to work directly and indirectly with drug companies in the development of new drugs for potential use in the treatment of narcotic addition.

NIDA and NIAAA are working with relevant private and public organizations, state and local government agencies and public interest groups to encourage their support of treatment programs and the expansion of third party funding.

In 1983–1984, the program will continue to emphasize the integration of the latest research findings into the existing treatment network. Priority attention will be given to developing treatment services for youth and for the expansion of private sector support to early intervention and treatment programs.

RESEARCH

Prevention and treatment approaches have been revolutionized in the past few years by increased knowledge concerning the serious health consequences of a number of drugs; the interrelationships of various drugs, including alcohol, in drug abuse; and the need to address abuse within a range of related social, psychological and physical problems that may be as varied as the population affected.

Federal measurement programs provide a wealth of information which can be utilized to describe drug-related health problems; monitor the incidence and prevalence of nonmedical drug use; assess the negative health consequences associated with certain drugs in the nation, states and major metropolitan areas; and plan research, treatment, law enforcement and other operational activities.

DEA drug analyses programs and the NIDA funded Marijuana Project provide a solid foundation for an expanded drug analysis system concerning the composition, potency and probable source of illicit drugs.

In 1981-1982, significant progress has been made in understanding biological factors which may predispose some individuals to drug and alcohol abuse and tend to make others resistant.

National Institute on Mental Health (NIMH) has several projects underway which will strengthen current hypotheses concerning the relationship of drug and alcohol consumption with overall mental health.

A study on Dynamics of Delinquency and Drug Use indicates that, as with most social problems related to drug and alcohol abuse, effective prevention and treatment must address a range of factors.

Research findings announced in 1982 represent a significant advance in the ability to provide accurate, credible information concerning the risks associated with marijuana use.

NIAAA research suggests that attempts to develop commitments to conventional goals, such as education or occupational careers, as well as changing attitudes toward the law, may be effective in promoting a reduction in the use of alcohol by adolescents.

Research on the developmental progression of drug use in adolescents indicates that prevention and intervention programs should focus on alcohol and marijuana, which serve as the "drugs of introduction" to other drugs by young people.

NIDA is investigating family therapy approaches to drug abuse treatment and methods for using schools to identify and provide effective services to aid drug abusing youth.

Studies have begun to reveal which types of treatment are most effective for particular types of individuals with serious drug problems.

Three new drugs are under development which hold promise as effective drug treatment agents.

In 1983-1984, ongoing research concerning the biological, psychological and social determinants of drug and alcohol abuse and its effects on different types of individuals is expected to have a dramatic effect on treatment and prevention programs.

INTERNATIONAL COOPERATION

National and international efforts to alleviate the problems caused by drug abuse and to reduce the demand for drugs through a variety of deterrent activities must be supported by the world. The United States has assumed a lead role in international demand and supply reduction through diplomatic initiatives, technical assistance, training and information exchange. Drug abuse is not just a health and crime problem, but a matter properly integrated into our foreign policy as an issue of national responsibility under international treaties. Therefore, we have worked to encourage the governments of other countries to take action against production of illegal drugs and to recognize the impact of illicit drugs within their own country.

Demand reduction programming is integrated into country strategies through ongoing conferences and planning sessions for U.S. narcotics coordinators posted around the world.

The United States actively supports and participates in United Nations, other international, and regional programs for demand reduction, collaborating on research projects and providing advice, technical assistance, materials and funding.

United States participation in drug scheduling decisions under the Convention on Psychotropic Substances and the Single Convention on Narcotic Drugs has a major impact on the availability of and access to controlled substances internationally and within the United States.

Each year, the Bureau of International Narcotics Matters (INM), NIDA and NIAAA provide technical assistance to help countries develop effective treatment and prevention programs. In 1982 assistance was provided to Malaysia, Pakistan, Ecuador, Peru, Thailand and Burma, among others.

The United States Information Agency (USIA) plays a major role in the international strategy by communicating demand reduction messages to overseas audiences, thereby heightening public awareness and official recognition of internal drug abuse problems and encouraging these nations to undertake narcotic control and demand reduction programs.

In 1983-1984, the United States will continue major initiatives and ongoing programs to encourage producer, transit, victim and other donor nations to recognize the global nature of drug abuse and to increase demand and supply reduction programming.

DRUG ABUSE IN THE ARMED FORCES

The Department of Defense (DOD) has established the goal of a force that is free of the effects of drug and alcohol abuse and has undertaken major initiatives, many in close cooperation with other Federal agencies, to achieve this goal.

A technical breakthrough has enabled DOD to include cannabis, the most widely used illicit drug in the military, in the urinalysis detection and deterrence program.

A media campaign, initiated in 1981, emphasized both the danger in abuser poses to the unit and the opportunities available for those who want help. In 1982, radio and television spots were developed which emphasize the incompatibility of alcohol and drug abuse with a healthy lifestyle.

In 1982, DOD intensified efforts to prevent intoxicated driving. A DWI Action Planning Conference brought together personnel from the four Services and Federal, state and local agencies to exchange ideas and develop objectives for the Secretary of Defense disseminated DWI policy. Ongoing activities with the National Highway Traffic Safety Administration (NHTSA).

DOD works closely with the VA on treatment matters concerning discharged military personnel and is developing an agreement which will provide treatment services to active duty personnel who have minor alcohol and drug abuse problems.

The ACTION Vietnam Veterans Leadership Program is working to dispel the damaging and incorrect stereotypes concerning the Vietnam veteran and drug abuse. By affirming the integrity of military service during the Vietnam War, the program helps to restore a national perception that military service is an honorable calling which is not compatible with drug or alcohol abuse.

DOD is working closely with volunteer groups and other Federal agencies to develop a community-based prevention program which will focus attention on school-aged dependents.

Department of Defense surveys show significant improvement in drug use trends in the military, including a sharp decline in current marijuana use by junior enlisted personnel between 1980 and 1982. In 1983–1984, successful programs will be continued and improvements are planned in the areas of non-residential treatment, community-based prevention programs, and formal programs for students attending DOD schools.

CONCLUSION

Emphasis will continue on prevention of drug abuse, especially among the youth and on all drugs of abuse, including alcohol. We will continue to emphasize the importance of the private sector as an integral part of the national drug abuse prevention campaign. The law enforcement community also has an important role in the overall prevention effort.

We have stopped pretending that there is one single answer, the "magic bullet," that, by itself, will solve our drug abuse problems. We have encouraged a sense of personal and corporate responsibility for drug abuse.

I believe that the initiatives of the Administration in both drug law enforcement and in the health-related areas are proving effective in reducing drug abuse in the United States. Possibly more important is the fact that they have the potential for making a dramatic reduction in future drug abuse in our Country. By placing emphasis on long-term objectives and focusing on efforts to prevent drug abuse among our youth, we have a real opportunity to make a major change in the drug abuse patterns of the past decade and provide a healthier future for our children and our Country. Thank you for your continuing support.

FEDERAL DRUG STRATEGY—1983

WEDNESDAY, NOVEMBER 2, 1983

House of Representatives,
Select Committee on Narcotics Abuse and Control,
Washington, D.C.

The select committee met, pursuant to call, at 9:45 a.m., in room 2337, Rayburn House Office Building, Hon. Charles B. Rangel, presiding.

Present: Representatives Charles B. Rangel, William J. Hughes, Sam B. Hall, Jr., Solomon P. Ortiz, Benjamin A. Gilman, Lawrence Coughlin, Michael G. Oxley, and Gene Chappie.

Staff present: John T. Cusack, chief of staff; Richard B. Lowe III, chief counsel; and Elliott A. Brown, minority staff director.

Mr. Rangel. Good morning, colleagues, distinguished witnesses, and all of you involved in the awesome problems of drug abuse that face our Nation today.

Our hearing this morning will concentrate on the Federal strategy for drug abuse treatment, prevention, research, and review, as we had yesterday the 1982 Federal strategy. We will focus on a wide range of issues, and specifically treatment, prevention, and research, to try to determine to some degree the priorities that are here in the administration to see what the responses to the local and State needs are, and also to find out how this Federal strategy is being implemented by the administration.

We do hope on this committee to bring the needs of local and State government to the attention of the administration, and we would also like to review the cooperation that we are receiving from the private sector in the area of rehabilitation, prevention, and education.

We would like to see what gaps, if any, that exist, what youth and minority populations are being served, whether or not the current economic problems we face have any impact on the number of people who have been exposed and are indeed abusing drugs, to see whether or not the Federal Government is responding to these changing factors, to see what the statistical data is as it relates to a decrease or increase, what areas we should be concerned about, whether or not we should be targeting.

And also, I would like to point out that we have with us in the House, fortunate to have him to be the key witness this morning, the sponsor of the National Drug Abuse Education Week. It is interesting to note that we have such a dedicated legislator that really sets the standard for all of us in this country, and more specifically in this Congress.

That even though he was invited to be with the President of the United States yesterday as he signed into law the resolution designating November 2 to 9 as National Drug Abuse Education Week, that he was more concerned with the fact that his voting record remains the high standard that we all seek to achieve.

And for those reasons, his charming wife, who was described by his son as his beautiful mother, and his daughter, were at the White House in lieu of our great friend, Congressman Bennett.

And so it is a great honor for us to have someone like that in the House of Representatives, someone who has suffered a personal tragedy, but has tried to assist others in understanding the problem before it reaches them.

Congressman Bennett, this committee and its members have tried to tell heads of states, so many of them who refer to us as a consumer nation, and there were so many people in Europe who were saying, "we may grow and manufacture it, but it is your problem because you have the demand."

And as we now go around and visit these very same countries, we find unfortunately they did not learn from our mistakes, and that they too are witnessing the same type of problems with the young people.

You make our committee stronger by agreeing to come here to be our first witness. And, of course, the President has made us all feel proud in lauding the work that you have done nationally when he signed your resolution into law yesterday when Congressman Ben Gilman and I were privileged to be there with your lovely family.

So on behalf of the full committee, we thank you for opening up this morning's hearings.

[The opening statement of Mr. Rangel appears on p. 299.]

TESTIMONY OF HON. CHARLES E. BENNETT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. BENNETT. Thank you, and I thank this committee for the wonderful work that it is doing. Obviously, I would not have gone public with the problem in my own family, if I could evade it, and think that it was possible for me to do my duties and do otherwise. But to share with other people who have this problem or have had this problem is something that I think is important. It might be helpful.

There are some thoughts that I have that I will just briefly touch upon. I am sure that they have all been before your committee thoroughly. I do have a strong feeling that despite the fact that we have made great strides with the comitatus legislation of a few years ago, and despite that I feel that there is a need for an overall drug czar, whatever you want to call him, somebody who is really in authority, and that his territory is the same as all of the United States. I think that that is sort of necessary to be done.

There are other little things that can be done. I am cosponsoring with people in the Senate criminal penalties legislation, antigang type organized crime legislation. Also, here in the House, some of the legislation that has to do with pilot's licenses. It actually brings about a revocation of licenses when a person has been convicted of activity in that drug smuggling area.

Then with regard to bail cases, there is a special problem with regard to bail. I have set that out in a bill which I have introduced with others, which allows the judge to deny bail in many cases where, as a practical matter, justice is not going to be achieved unless the bail is differently handled than most other cases. And that is perfectly constitutional, and I hope that that will be done.

Then finally, I have introduced a bill which provides that the President must certify that a country is cooperating in the drug fight in order to get foreign aid. We do have something on the statute books like that something which says that the President can find that if he wants to do so. But this law which I have introduced I think is much better. It actually requires the President to certify that the country involved is cooperating in this activity.

Now finally, as I close my remarks, I want to say to you that I have a strong feeling that despite all of these very needed things that can be done in the way of putting on heavier penalties, and spending money in catching smugglers, applying the penalties and all of that, at the very heart of it is what you have touched upon, Mr. Chairman, and that is the consumer aspect of it.

That is something that I can speak about, and how subtle, and how dangerous, and how difficult this is for all of the American mothers, fathers, children, in this country to face. If we cut down the consumption, obviously there will not be the sale.

You will not have to worry about spending all of this money, and you will not have to worry about all of these various technical things before the court, and things of that type if consumption is cut. So that is really the main thing that we need to do that, is to get across to people the grave dangers in the consumption of these drugs.

It would seem obvious that there would be this knowledge on the part of people, but that is actually not so. So anything that you can do in that field to be helpful would be great.

I think that all States, should be encouraged to have programs where they do educate people in this field, and I not think that they are doing it enough. I personally feel that the drug curse upon America could be much worse than the curse coming from Soviet imperialism or arms.

I appreciate very much you letting me be here. I congratulate your committee on what you are doing. If there is any way at all that I can be of any help in a monetary, or in a time way, or whatever it is, it would be a privilege for me to do it.

Many parents who have experienced this in their own lives, feel deep remorse, a self-guilt, a terrible problem that comes upon the lives of the older people who are affected by the throwing away of lives of younger people that they have tried to help develop.

So if I can keep this pain in some way from anybody, or if I can keep any particular young person or older person from going into drugs, I feel just as you do, that this is a great opportunity to do something very positive. And if I can help in any way, it will be a pleasure.

I appreciate you letting me be here. God bless you.

Mr. **Rangel**. Mr. Bennett, there is no sense in feeling guilty, because it is hard for us to understand God's work, and that is out of our congressional field. He works in mysterious ways. As a parent, we just have to hold each other's hands when it comes to our children.

But I would like to ask you. I do not think that any administration has done more to focus attention on drug abuse than this administration. Certainly it covers the private sector to get involved. Congressman Gilman and I joined with your family in commending them for that before the ceremony.

We were there for the support of the chemical people, and Metropolitan Life and everyone is pitching into this. But yesterday when we had our hearings, the administration was making it abundantly clear that local and State people are going to have to learn how to do more with less.

In every area that we looked at the budget, even though there was a conflict on the method that we achieved the figure, clearly there have been budget cuts. In the State of New York, there has been a 50-percent slash in the Federal funds that are available for education, prevention, and rehabilitation.

Just last year, there was a $10 million cut on the local effort. They talk about giving the States more discretion which, of course, is a good sounding, good government thing, let local governments decide what they want to do. But they do not talk about the 30-percent slash or reduction in the amounts of money, or the fact that when drug addicts have to compete with other needs in the community, that they do not make out too well politically in getting a fair share of that State allocation.

We tried to ask them whether there should be a person in charge. Maybe they do not like the word czar. But clearly, whether we are talking about law enforcement, treatment, or prevention, someone—I think that we heard yesterday to our embarrassment that Dr. Turner has met with the President alone to discuss these things twice in the last 2 years, and the last time for 10 minutes.

Which you may not need a lot of conversation, but certainly if people like you, me, and this committee, and a substantial number of Members of Congress believe that this threat is just as dangerous as the Communist threat.

I was asked to give a talk to Wall Street brokers. I thought it was because of my awesome and powerful position on the Ways and Means Committee, that they wanted an economic projection in order for them to make good and sound advice. What did they want to talk about, how they could prevent drug addiction from spreading with their brokerage firms that were doing business with them, and the impact that it was having on productivity. Clearly, it permeates the private sector.

I am glad that you spoke out for the czar. I hope that maybe you can help us. First of all, I am making a commitment to the legislation that you have, and I am asking staff to bring it before us.

Second, when you talk about help, we would like to share with you where there have been cutbacks in this administration, and hope that we can get your help, and may ask what has been your experience in Florida, since this has been the area that the administration has been the proudest of.

Mr. Lewis of this committee invited us to review what was happening in south Florida with all of the task forces. Everyone agreed that it is a heck of a lot better than it would have been without the task force. But that there is more cocaine there than ever before. There is more abuse than ever before. There is more corruption than ever before. The sheriffs, who have the basic responsibility to enforce the law, they have never had a meeting with the Federal officials.

You are from Florida. What has been your experience in terms of the administration's war against drug abuse, have you seen the impact?

Mr. **Bennett**. Both the positive and the negative side. The negative side is, as you have pointed out, that despite all of the efforts that are being made in some categories, that some things are worse. They have certainly seized a lot more material than they have seized before. There are certainly a lot more people being arrested and there are certainly more penalties being put on people.

The problem is this epidemic among the American people of the use and abuse of these drugs, and how to get a handle on that. All of these other things that we talk about, about the penalties, and even the czar aspect, and all of that, they are not really going to solve it.

The only thing that is going to solve it is that the people of America turn their backs on drugs. One thing that young people need to do is to realize that when they take themselves out of our society, they are really not just independently using their bodies and controlling their life, but they are actually causing great pain to society as a whole, and they become also a great financial burden to society as a whole.

So they just do not entirely affect their life on a long-time basis. They commit what amounts to suicide and nonproductivity. A lot of these things have got to be addressed, and they have to be in the hearts of people who are basically good people. The American people are good people.

This has to be addressed from the standpoint of trying to keep them from consuming. I think that that is the greatest hope. The statistics are both ways in Florida. I urged from the beginning that we not have just a Florida facility, but instead that we have a national facility, and we might concentrate if you want to at one particular time on Florida.

I think that it is a mistake to have boundaries and just little cul-de-sacs in the country where the drug people are known to be active. You ought to make them theoretically think that we are going to be everywhere, and then just pounce on them where you want by targets of opportunity, where you want to do it.

The States are going to have to get much more interested in it. Churches are going to have to get more interested in it. We are all going to have to do a lot more ourselves.

I am on a good number of boards of organizations like Straight, and things like that, who are trying to fight drug abuse. And we are going to have to be more and more concerned about that than we used to be. I think that all are going to have to put their shoulders to the wheel.

But basically, the lack of consumption of the drug is the thing that is really going to turn the thing around. So this Education Week, as superficial as it may look, if it really gets people to look at it and think about it, it would be good.

I was distressed by the fact that today there was not very much publicity. In fact, I did not read a line in the morning paper, any morning papers, about this, and no TV on it at all. I was kind of distressed about the fact that the media would not realize the necessity of doing something in this area.

Because the media is a very concerned part of our society and if it is not going to help fight drugs, then there is not going to be much society for them to sell their media to. And maybe there is a reason for this. Maybe they are waiting for tonight when the wife of the President and others are in some sort of program on that.

Maybe that is the reason. But if they are just going to stay off and say, no, we would rather take care of Larry Flynt, and those little tiny things when a great big thing is going on in our face, I think that it is very dangerous.

Mr. RANGEL. We would like to thank you for your time. I know that there are other members, Mr. Gilman, who would like to thank you. Mr. Gilman.

Mr. GILMAN. Thank you, Mr. Chairman.

I certainly want to welcome the gentleman from Florida, and commend him for his effort in introducing the resolution on National Drug Education Week, and for having the opportunity to meet his beautiful family yesterday at the White House ceremony, in which the President kicked off National Education Week.

I was pleased to cosponsor the legislation. And the gentleman's remarks are quite correctly pointed that the media would put on the front page someone who gets involved in an unfortunate incident involving drug abuse, and overdose, and something of that nature, but when it comes to promoting and raising the public's consciousness, I am afraid that we are not getting the kind of attention that it deserves.

So often in our recent trip to Latin America when we met with leaders in Latin America, and tried to convince them of the importance of eradicating and reducing supply, they would point the finger to us, and say "you reduce demand, then there will not be any problem for supply."

So while I take exception to that kind of a response to our need to do something, I think that there is some merit to their contention that we do have an obligation to battle it out on the demand front as well as the supply front. And that we do have an obligation to educate the public, and this is an excellent way.

And I want to commend the administration for embarking on and designating November 2 through 9 of this year as National Drug Abuse Education Week. Your leadership in your resolution was particularly appropriate at the time that the Chemical People program is going to be aired tonight on public television. There have been some 10,000 townhall meetings arranged around the country in conjunction with the "Chemical People" program, which is an educational program sponsored by some of the private sector.

The First Lady has taken an active role in it. Some of us have helped in the promotional screening for this program. I would hope that all of our colleagues would take part in this National Education Week, and encourage our communities to become involved.

We cannot do enough about raising the public's consciousness to this very critical program. And we are certainly grateful to you and Mr. Bennett for having led the way in the Congress in promoting this.

But I cannot say it enough, that we cannot do enough in educating our young people about the dangers of drug abuse. We are certainly thankful for your initiatives in this matter.

Mr. BENNETT. If I may quote and repeat what I said on the floor the other day, "If the First Family accomplished nothing else in these Reagan years, this fight against drug abuse would justify the leadership that the President and Mrs. Reagan have on their shoulders. God bless them both."

That is what I said on the floor, and I repeat it here today. And I appreciate the opportunity to be here, and your wonderful work.

Mr. RANGEL. Thank you.

Mr. BENNETT. Thank you.

Mr. RANGEL. Thank you, Mr. Bennett.

Mr. BENNETT. Thank you.

Mr. RANGEL. We have a few minutes. Maybe what we will do is go vote. And Dr. William Pollin, who is Director of the National Institute on Drug Abuse, will be here with Dr. Thomas Pauken, Director of ACTION. As soon as the members return from this vote, we will start our formal testimony. We will recess for 10 minutes.

[Whereupon, a short recess was taken.]

Mr. HALL. The select committee will come to order.

As has been stated previously, we are privileged to have Dr. William Pollin, Director of the National Institute on Drug Abuse with us today.

The chairman has had to go to another meeting, so I will chair until he returns.

Dr. Pollin, we are happy to have you, and you may proceed as you see fit.

TESTIMONY OF DR. WILLIAM POLLIN, DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. POLLIN. Thank you, Mr. Hall.

I appreciate the committee's invitation to discuss the drug-abuse problem in America, and the role of the National Institute on Drug Abuse. I would like, before I get started with a summary of my statement, if the subcommittee approves of that summarization, to express my personal appreciation and gratitude for the existence and the work of this select committee.

Much mention has been made of the special and very important attention that has been paid to this problem by the President and the First Lady. They have made major contributions. The existence of this select committee, and the dedication and work of the members, the chairman, and the staff are an important additional initiative which has certainly helped in calling the attention of the Nation to the problem and I believe, in achieving some significant turnabout in terms of the scope of the problem.

With the chairman's permission, I would like to summarize my statement, which has been previously submitted.

Mr. HALL. You may summarize, and your statement will be made part of the record.

Dr. POLLIN. Thank you, Mr. Chairman.

As the committee is well aware, drug abuse is not only a major public health problem, but as identified by a recent Secretary of HEW, addiction disorders can well be considered this Nation's No. 1 health problems.

These disorders as a group account each year for more than a quarter of all deaths that occur in this country.

The committee is aware of the basic content of the Federal strategy: the interaction of supply reduction and demand reduction; NIDA has a key role to play in the area of demand reduction.

We believe that supply reduction is of the greatest importance. And certain figures lead us to conclude that with respect to drugs such as cocaine, supply reduction accounts for perhaps 90 percent of the reduction in levels of use which otherwise would occur were the supply reduction effort not in place.

Despite the great importance of supply reduction-efforts, as has been mentioned earlier this morning, demand reduction clearly has a very basic role to play. I would like to present some data this morning which NIDA has obtained through its national surveys and additional data from organizations throughout the country, to summarize our view of the present status of the drug-abuse situation in the country.

The four points that I would like to emphasize in describing the overall national situation are as follows. First, drug abuse continues to be a very severe problem. However, after 20 years of rapid increase during the 1960's and 1970's, overall drug-use levels in this country clearly have leveled off, have begun to decrease, and are currently showing an accelerating decrease.

Second, although this decrease is true for overall prevalence, that is for the total number of users in the country, and is true for most drugs, at this stage in what I believe will be a continuing decline, significant exceptions do exist with regard to individual areas, subgroups of users, and individual drugs.

Third, that despite the significant trend reversal and improvement which has occurred since 1979, the great bulk of the increased problem of drug abuse in this country, that is 70 to 80 percent of the increase in drug use which occurred during the 1960's and 1970's, remains. And thus, although trend lines and trend changes are encouraging, the problem continues to be a problem of the greatest seriousness and moment. Further, there are a number of factors which threaten a worsening of the situation, such as the clear evidence of a substantial increase of potential supplies of cocaine and a significant decrease in the cost of cocaine.

Finally, it is clear that the recent reductions and the recent improvements that I will summarize momentarily for the committee result primarily from demand reduction. That is, though supplies have continued to be as available, and in some cases more available, nonetheless we see this downturn in use levels.

If I could now summarize some of this data for the committee, Mr. Chairman. I would like to run through a series of charts rapidly. First, a chart which shows the increase by the highest using age group in the country, the young adults, from 1960 to 1979 when it peaked.

That was an increase of over tenfold, from 5 percent to 70 percent. Notice, however, that at the beginning of 1979, although the opportunity to use marihuana, namely the availability of the drug, continued to increase, the actual levels of use began to decrease.

Notice, however, that although the decrease is real and quite sturdy, that nonetheless we have only regained roughly 5 percent of the ground that we lost during this 20-year period of continuing increase.

If we took the age group that we are even more concerned with, namely teenagers, this increase would be even more marked, and in percentage terms it would be twentyfold to thirtyfold, 3,000 percentage increase among our young people.

However, more intense levels of marihuana use have shown an even more dramatic decrease. Daily use of marihuana by high school seniors peaked in 1978 at close to 11 percent. Between 1978 and 1982, it has decreased almost one-half, so that it is now down to 6 percent. This decrease is continuing.

This decrease is not limited to marihuana. It is true of the majority of the 16 categories of drugs which our national surveys monitor each year. If we take cocaine, we see a marked threefold increase in the use of cocaine between 1976 and 1979. But, since 1979, both in the young, adult household population and high school seniors, we see a leveling and a decrease in use.

I think that cocaine is a good drug about which to make the point specifically that I made in a general way in my opening remarks. We are certain that there has been an overall decrease in terms of the total number of people in the country using cocaine.

All of the studies, our two surveys, and individual State surveys show that. However, it is quite possible that at the same time as you get a decrease in the number of people using it, that within the 5 million who are current users at the present time, you can get an increase in the level of use and the danger of the pattern of use.

Thus, you can have a period of time during which overall decreases in national use are nonetheless consistent with increasingly dangerous patterns of use within some subgroups within the country.

This chart shows again the point that was made on the first chart. That the decrease in use among high school seniors and in the country as a whole, which began in 1979, occurred despite the fact that the availability of marihuana, which is shown by this orange line, continued at a high and actually increasing level.

If availability was high and increasing, but use came down, how do we explain a change in use patterns? We think that we understand that fairly well. At the same time that use peaked and then began to come down, we began to see a dramatic, continuing, and increasing change in terms of national attitudes and national perceptions.

It is exemplified here in the data with regard to high school seniors. Until 1978, there had been a decreasing level of concern, a decreasing perception of marihuana as a dangerous drug among high school seniors. In that year, the perception turned around, and it has increased steadily since then.

The percentage of high school seniors who see marihuana as a dangerous drug, and other data which indicate the percentage of high school seniors who disapprove use by their peers, has increased. And it is clear that that increased perception of health risk is one of several important factors which have led to the decline in marihuana use.

The data that I have been showing is derived from a number of national surveys, which NIDA has sponsored, and have been done yearly or biennially throughout the 1970's. We feel confident that there have been trend changes of the types that I have described as a number of our surveys agree and are also consistent with the many surveys and polls that are done by State or private organizations in the country.

These next two charts chart the most recent data reported in August 1983 with regard to marihuana use and marihuana attitudes in California, which has always been a bellwether State, and which in the past led the Nation with regard to permissive attitudes toward drugs, and in increases in drug use.

Again, these data are entirely consistent with the data of our own national surveys and show not only a continuing, but an accelerating tendency in these two same directions.

Again, we focus on marihuana for two reasons: It is the most commonly used illicit drug. It is also clearly the gateway drug which determines whether young people particularly will go on to use other drugs or not.

When we compare marihuana use trends among adult smokers in California in 1979 and 1983, we see a one-third decrease in terms of the percentage of California adults reporting their use of marihuana.

We have selected just a small part of the data, but there is more in the testimony. It is clear that this decrease in the use of marihuana again is not due to decrease of availability. It is due to a considerable increase in concerns about health risks, and a considerable change in terms of the general level of acceptance of the notion of the use of marihuana and the use of drugs.

Here, I think, is one of the most encouraging sets of data for us to take note of. Between 1969 and 1979, there has been a steady and very substantial decrease in the percentage of California adults who were concerned about the use of drugs, who wanted to see stricter enforcement of antidrug laws, or stricter laws enacted.

Again, there has been that same dramatic change in attitudes. Between 1979 and 1983, there has been an increase from 36 percent to 54 percent of Californians who are in favor of either enacting stricter laws against marihuana or stricter enforcement of present laws with regard to marihuana.

Mr. HALL. Would you put that last chart back up there for just a moment, please.

What is the yellow?

Dr. POLLIN. The yellow is the percentage of Californian adults favoring legalization.

Mr. HALL. Legalization?

Dr. POLLIN. Yes.

Mr. HALL. All right.

Dr. POLLIN. And we see the appropriate mirror converse.

Mr. HALL. Fine.

Dr. POLLIN. We think that the substantial body of data which has become available in the past 5 years, first substantial new data concerning the health consequences of the use of marihuana and the use of other drugs, the much greater success in communicating this data to the country, additional fundamental changes in demographics, and a number of other factors which we do not have time to go into today, have brought about a very different situation in this country.

Drug-use rates are coming down, crime rates are coming down. The divorce rate which had been going up for 15 years has become to come down. Automobile accident rates are coming down.

Now in all of these instances, we are still left with very, very serious problems. And in all of the instances that I have mentioned, although there have been consistent and related trend changes, we are still at a situation 80 to 90 percent worse than we were when these increases began in the early 1960's.

Nonetheless, a very important change of direction has occurred. The need now, it seems to me, is on the one hand to take note of and be aware of the change in underlying trends, but at the same time to be equally attentive to and equally concerned about how much of the problem remains. This is particularly true in those situations where we see that there are multiple factors which could cause a worsening once again—factors such as increased supply, decreased cost, and the like.

Now the kind of data that I have presented is just one of the types of data that NIDA has been involved in collecting the past 10 years. We are fortunate in that we have developed a data and surveillance system in this country which is really unparalleled. And we are able to speak with greater certainty with regard to national trends than any other country in the world.

We can say, unfortunately, with some degree of certainty, that levels of use by our young people are probably greater than that by young people in any other industrialized country. This is another measure of the severity of the problem.

I mentioned that although the overall trends are encouraging, there are still very serious continuing problems, and in some instances increasing problems. With regard to heroin, it is not clear that there has been the same level of decrease.

Certain other data sources which we use to measure heroin trends, such as DAWN data, were showing continuing increases in the heroin-related mentions until very recently during this current year.

Our major concern with regard to heroin is the possibility of the reappearance of the kind of heroin epidemic that had occurred in the sixties and seventies. Thus far, we see no evidence of that. That is, there is a continuing increase in the age level of patients coming in for treatment or coming into medical emergency rooms with heroin problems.

The reverse would be true if we were beginning to see a reappearance of a heroin epidemic.

We are now particularly concerned about the risk associated with cocaine. Cocaine has been shown in a wide range of studies to be the most abusable drug that currently exists. It is the one drug where experimental animals, primates, if given a choice between getting cocaine, or getting food, or water, will starve themselves to death in order to continue to get cocaine.

And the fact that we know that there are substantial increases in the availability of the drug in the foreign source countries, and substantial reductions taking place with regard to the cost of cocaine in this country, is a source of great concern to us.

We have seen in a number of South American countries an explosive increase in the use of coca paste by young people, which is a terribly dangerous pattern of addiction. We hope that the overall change in drug use trends plus a number of priorities that we have underway will help in conjunction with the strong enforcement effort to avert what could be a new national tragedy, and that is not too strong a word.

Cocaine is the drug, I think, that shows most clearly how important supply reduction is, apart from our efforts in demand reduction. Our studies convince me that if cocaine were as easily available as cigarettes or alcohol, instead of having 5 million cocaine users, we would have somewhere between 50 million, which is the number of Americans who are cigarette smokers, and 100 million cocaine users; 100 million is the number of Americans who are current users of alcohol.

The fact that we only have 5 million clearly is the result of the sum total of legal strictures and enforcement efforts which reduce by a factor of 10 to 20 the size of the cocaine problem that we have to deal with.

In addition to collecting the kind of data with regard to drug use trends, NIDA is involved in a variety of research studies having to do with treatment and the treatment system. One issue which I know is of concern to the committee is the adequacy of the treatment system at the present time, especially since the switch to the block grant mechanism.

We have been monitoring the dimensions and the activities of the treatment system since 1977 with a system which we call NDATS, which provides a rather total and complete picture of the treatment system.

It receives data from the over 3,000 separate treatment units which together make up the national treatment system for drug abuse. These data show that as of September 30, 1982, in this total national treatment system, the 3,000 plus units reported a total of $533 million being expended by them for treatment services.

This represented an increase of close to $50 million over the total sums expended in 1980, when the total system expended $486 million. This is despite the decrease in those funds which went through NIDA, the funds which after 1980 became the block grant funds.

But at the same time that those funds which now constitute the block were showing some decrease, there were significant increases in the funds that were derived from State governments, from local governments, from private insurance and other private sector funds.

So the total dollars available to the treatment system had continued actually at a somewhat higher level than previously was the case. There were some one time situations that existed in 1982 with regard to carry-over dollars. And we will have to await further reports to know what the total health of the system is.

We know again that nationally the number of treatment slots has remained essentially the same with a slight decrease of perhaps 8,000 from approximately 203,000 to about 195,000. We know that the utilization rate of those treatment slots has remained at a level slightly below the levels that have been seen in earlier years.

That utilization rate which is 88 percent in 1982 indicates that there was still on a national basis some 12 percent unused capacity in the treatment system.

Now within this overall national picture, we are aware of the fact that in individual localities and States there can be difficulties, there can be major problems. It will take some further time for us to be able to analyze individual State reports. So where states report that they are having difficulty in finding adequate treatment capacity, we do not know to what extent that results from decreases in the block grant funds, versus the fact that in that particular State, they have not as yet been as successful as the national average in terms of increasing other sources of funds from State or local communities, and from the private sector.

I have summarized in the statement the several areas of research which are research priorities for NIDA. Each year we support 400 separate research projects that cover a very broad range, from understanding the basic biological and psychobiological effects of drugs, why certain drugs are abused and others are not, to determining why certain individuals are vulnerable to abuse, and others are not.

We have made major breakthroughs in a number of these areas. We think that the substantial additional information that has been developed from NIDA-supported research concerning the health consequences of drug use is one of several reasons why the improvements have occurred that I have described with regard to national trends.

In view of the time and the considerable witness list that I know that the committee has before it, I will not at this point say anything more about those research efforts, nor about our considerable additional efforts in the area of working with local community groups, parent groups, our prevention efforts, and our communication efforts.

We feel that although there is a huge job remaining, that basically in terms of bottom line consequences, as well as in the description of process activities, we have been successful in moving toward our goals, although there is still a very, very long way to go.

In conclusion, Mr. Chairman, we all know that drug abuse is a problem that cuts across all social, economic, and age groups, and that all of these deserve our attention. But at a time when it is necessary to extract maximum benefits from the Federal investment, it is extremely important that we set clear priorities.

During this current fiscal year, our efforts will focus on continuing to support a comprehensive and well-balanced basic research program in drug abuse, to define and implement successful model prevention treatment strategies, to move toward a position where the results of this research and the application of these methods can be confidently disseminated to the community levels. Develop new data systems to accurately and comprehensively track the utilization of drug abuse treatment programs and to describe patient addicts in treatment is another priority area.

In our efforts to combat youthful drug abuse, we will continue our technical assistance to private sector or family based prevention activities, such as those of local parent groups. Efforts in all of these areas, we believe, are clearly already paying dividends.

However, it is very clear that drug abuse remains one of our most serious public health problems, and that our response to it must be flexible and multifaceted.

Thank you for the opportunity to talk about these important issues, Mr. Chairman. I will be very glad to answer questions that you or the committee members might have.

[The prepared statement of Dr. Pollin appears on p. 303.]

Mr. HALL. Thank you, Doctor.

Your statement cites a number of studies and surveys that show the abuse of many drugs leveling off in many geographic areas among certain populations. Information that has come before this committee from treatment professionals and others show that the abuse of heroin and cocaine as well as the demand for treatment services is increasing.

Moreover, other data would seem to contradict the position made in your statement that DEA recently announced that the price of cocaine is plummeting around the country with availability higher than ever before.

You claim, and I am quoting, that, "overall cocaine trend has shown some sign of leveling."

How do you reconcile those apparent contradictions?

Dr. POLLIN. Mr. Hall, I think that the contradictions are more apparent than real. A decrease in the price of cocaine can result either from a substantial increase in supply and/or a decrease in demand.

The fact that there is more cocaine available in this country, and that the price is coming down does not in any sense necessarily reflect an increase in use. Actually, if use were increasing rapidly, we would expect price movements going in the opposite direction.

With regard to the increased treatment demand, as I indicated in my earlier remarks, we are very much aware of the fact that, although overall national trends are, in our view, clearly showing a basic reversal of what had been a 20-year increase, some subgroups will show increases in overall levels of use, we know from previous drug epidemics that in a period when overall trends are moving in a favorable direction, there will be subgroups of users whose use increases when demand comes down, and prices therefore come down. There will be an increased availability for that reason, if for no other reason.

The heroin addicts who are coming into treatment programs these days, who are coming into medical emergency rooms, for the most part represent older addicts, who, in the face of some increased availability, often return to the use of heroin at levels of use that they have been unaccustomed to.

So that although this is a time of mixed trends, I do not believe that there is any basic contradiction in the individual facts taken together.

Mr. HALL. If you agree that cocaine has fallen, the price has fallen from $60,000 per kilo to $28,000 per kilo in 1983, what do you attribute that to?

Dr. POLLIN. I believe that it is a result of two factors, Mr. Hall. I think that there clearly has been a substantial increase in the areas of cultivation in South American source countries. And the traffickers are getting increased supplies here.

But I think, also, it results from the fact that there has been an overall reduction in the number of Americans using the drug.

Mr. HALL. Do you have any DAWN data available for 1983?

Dr. POLLIN. Yes, we do.

Mr. HALL. Could you make it available to the committee, and share it with the committee?

Dr. POLLIN. Yes, we would be glad to.

Mr. HALL. Under the Alcohol, Drug Abuse, and Mental Health block grant, Federal support for substance abuse treatment and prevention efforts has been reduced by about 30 percent.

In your view, what has the impact of this rate reduction been on the ability of States to provide needed treatment services?

Dr. POLLIN. Mr. Chairman, I am not certain where the 30 percent figure comes from. The amount of moneys that previously went from NIDA through statewide service grants and contracts, which now go through the block grant, have shown some reduction. But I would want to compare with the committee our data with regard to the actual level of reduction. I do not believe that it is 30 percent.

And actually depending upon decisions made at the individual State level——

Mr. HALL. We will try to get with you, and work out that figure. We understand that the State and local people have given us those figures. And you can talk to staff about that.

Dr. POLLIN. I would just like to point out, Mr. Chairman, that potentially if States decided that the drug problem was their major concern, and used the flexibility in the current legislation to allot maximum dollars given by that flexibility to the drug problem, there could actually be an increase of between 5 and 10 percent in the amount of dollars going to the States.

Mr. HALL. Your budget for 1984 includes $973,000 for research training.

Is this amount adequate to attract sufficient numbers of new researchers to maintain a qualified pool of trained drug abuse researchers, and how has the uncertain funding for your research program over the past few years affected your ability to attract and retain qualified researchers, if it has?

Dr. POLLIN. We would like to see an increase in the number of individuals that we are able to involve in our research training program. We are currently involved in discussions within our agency and within the Public Health Service to see if within the overall levels of research training funds which have been appropriated, mechanisms can be found to increase the number of trainees.

With regard to the level of involvement of researchers in this area, on the whole we think that we have been outstandingly successful in involving researchers of the highest caliber in this area where previously they had not been involved.

And we think that it is for that reason that there has been this tremendous increase in the amount of basic and usable information available about drugs, which has in turn contributed to the improved drug use trends which I have returned earlier.

Mr. HALL. All of the testimony that we have heard, when I say all of it, a great portion of it, has indicated that the drug abuse by people on heroin and cocaine and the like is up. We know that in New York, they have done a great deal toward making it easier to use marihuana. I do not think that you can make any arrests for all practical purposes.

Your senior high survey a moment ago that you used, as I understand it, that does not measure drug use by young people who drop out before their senior year. I understand that that is about 17 or 18 percent. It also does not measure drug use of students who are absent on the day that the survey was taken, which I understand it 17 or 18 percent on any given day probably.

And, also, the survey is based on self-reports of drug use. There could be under-reporting. The NIDA household survey, it does not measure people not living in the households. And that is a self-reporting survey, also.

Are they accurate using those percentages of people who may not be there, who may not stay until their senior year, who are absent on the day that the survey is taken, is this high school senior survey, is it an accurate survey?

Dr. POLLIN. We think that in the range of surveys and the range of survey technology available today in any area, that these are outstandingly reliable surveys. We are aware of those problems that you mentioned.

Mr. HALL. My time is up, but I want to ask you one question. Can you equate availability of funds to success in your program?

Dr. POLLIN. In the best of possible worlds, additional funds usually provide for additional efforts. But I would never make a one to one relationship of the sort that the question indicates, no.

Mr. HALL. Mr. Oxley.

Mr. OXLEY. Thank you.

Doctor, I wonder if you would continue your answer that you started with Mr. Hall with regard to his question about the survey, if you would.

Dr. POLLIN. We are aware of the groups that are not covered by both surveys. We have carefully analyzed the range of possible distortion that would be brought about in worst case scenarios if we included those other groups, which undoubtedly are higher using groups.

And we have made that data public, and presented it. The important thing about the survey is the trends that they suggest rather than the absolute levels of use. And of the factors which you have mentioned, none have varied from year to year as the surveys have continued.

Mr. Oxley. Those surveys have used consistent criterion throughout?

Dr. Pollin. They have used consistent criteria. And, as I mentioned before, we only report these trends when the trends are consistent within both these two major surveys. The household survey is not based on self-reporting, but involves lengthy interviews within the homes. And also, it is consistent with the multiple State and private polls and surveys.

So there is a wide variety of data sources that all move in the same direction.

Mr. Oxley. Thank you.

Doctor, I looked at those graphs, and they were very effective in my estimation.

What happened to us in 1979 and 1980 that started that? It appears that there was a very perceptible change in our attitudes just about that 1979–80 period where apparently things started to turn around.

What in your estimate happened to us, what did we do right, or what happened to cause that change?

Dr. Pollin. I think that it is a multidetermined change, Mr. Oxley. I think three of the important factors are these. First, we really learned more about the health consequences of these drugs during the last 5 years of the 1970's than we learned in all of previous past history in dealing with the drugs.

Second, we were finally able to begin to communicate effectively our knowledge about the health consequences. There was an upsurge in community concern in community organizations as exemplified by the parents movement, which played a very major role in that communication process.

Until the late 1970's, there had really been a profound national debate as to whether the major drug problem in this country was society's overreaction to drugs. You will recall that the Shaeffer Commission, President Nixon's Commission on Marihuana, entitled its report, "Marihuana, a Signal of Misunderstanding."

Until the late 1970's, really the bulk of the communication to the American people suggested that it was society's overreaction and society's excessively strict legal sanction against drugs which were as much or more of a problem than the actual increase and consequences of drug use.

That debate got resolved in the late 1970's. And since the late 1970's, all legal initiatives have been not toward decriminalization, but toward stricter enforcement of laws.

And the third factor was a very important change in demographics. During the 1960's and 1970's, young people who were the group highest at risk as the percentage of the population were showing an unprecedented increase, a delayed reaction of the baby boom.

That increase peaked in 1978. It has been coming down since, and this clearly has important consequences for a large number of health and social problems.

Mr. Oxley. The figures that you used, and particularly the last area that you talked about, the third reason, would tend to equate with the crime statistics that we have seen recently, particularly in the demographic field.

Is that a fair assessment?

Dr. POLLIN. Yes; we have made a careful study of that and we are convinced that that is the case, that they are in fact related.

Mr. OXLEY. Doctor, do you think that the figures that we saw and the trends that we saw, the very positive trends that we saw, are an aberration, or indeed point to a long-term kind of commitment on the part of this country and on the part of its leadership to continue to see those positive trends develop?

Dr. POLLIN. I am personally convinced that they are not an aberration, that they are powerful, continuing, accelerating trends. I am also convinced that we could derail these useful changes and that the adoption of inappropriate or counterproductive social policies could reverse these encouraging trends.

Mr. OXLEY. What would you consider to be in that category?

Dr. POLLIN. There are still groups that are pushing the notion that we should be more permissive and accepting of the use of drugs by young people that we should decriminalize or legalize the use not only of marihuana, but of cocaine and other drugs.

I think that if that point of view were to regain the central impact that it had in terms of media coverage, if that point of view were to be enacted into law, I would be concerned that we would see a reversal of the encouraging trends, and a return to increasing levels of drug use in this country.

Mr. OXLEY. Doctor, one last question, if I may. I think that you stated correctly that cocaine is clearly the most dangerous substance right now that is being abused in this country. And I think that everybody would agree with it in terms of availability, effects, cost, and everything else.

What kind of statistics do we have from other Western countries, and do those numbers compare favorably or unfavorably with this country? And if indeed what I think is true, and that is that this country is a far greater user and abuser of cocaine, why is that, and why is it not so in other countries that are of comparable societal makeup?

Dr. POLLIN. The data from other countries is largely impressionistic. Impressionistically, it does not appear that cocaine has as yet spread to other Western countries, although we have significant reports that such spread is beginning.

One reason, I think, for the fact that these levels are so much higher in this country is the greater wealth of this country. Second, geographically, and in terms of the kinds of trafficking networks, it has been easier for traffickers to get the drug into this country.

We are seeing very rapid increases in the use of a particularly dangerous type of cocaine, coca paste, by young people in some South American countries, the countries of origin. That problem and its dangers has led these countries to a much greater awareness of the fact that this is a problem that we all share, and I would hope that there will be more effective policies in the countries of origin.

Mr. OXLEY. Thank you, Doctor.

Thank you, Mr. Chairman.

Mr. HALL. Our next person is Bill Hughes, who is chairman of the Subcommittee on Crime in the Judiciary Committee. And he has probably done as much work on one of these subjects that we have been talking about today as any Member of Congress. And I call on Mr. Hughes.

Mr. HUGHES. Thank you, Mr. Chairman.

And I apologize to the panel for not catching your statements in chief, but I have gone over them. I had another committee meeting at the same time.

Dr. Pollin, I have some questions that are a little duplicative of what has been asked thus far about trends in expenditures for treatment as well as prevention. And I have a chart that has been circulated by the committee, which indicates that the block grant program, if you will look at it, has seen a major decline in research that is committed by the Federal Government to both treatment and prevention.

If you look at the figures in 1980, we committed over $600 million in these two functional areas. That has decreased now to a level requested by the administration of $430 million. Enacted into the law recently was a total of $462 million, $32 million over what was requested by the administration.

But the funding each and every year has remained steady, even though inflation has meant that we have lost ground in addition to the major cuts.

And my question is just on what basis you would suggest that the States and private insurance and other agencies have picked up the slack. I want to know just where you get that information.

Dr. POLLIN. Mr. Hughes, we have been doing yearly or every 2 years since 1977 a comprehensive survey of all treatment units in the country. I would like with your permission, to provide the committee with copies of those and data reports.

These reports give descriptions of each separate treatment unit, over 3,000 in 1982, including the number of staff, types of treatment, type of patient, patient capacity, and utilization of capacity. They also, contain data concerning the funding for each of those individual treatment units.

Any such survey of individual treatment units has considerable room for variance and for error in terms of the final aggregated results, and there are a number of caveats which are contained in the report when one compares data from year to year.

Mr. HUGHES. The basis of the survey that has been done by NIDA?

Dr. POLLIN. That is right.

Mr. HUGHES. Let me, if I might, because there is a limited amount of time, and I do have a number of questions, let me just pick up on that a little bit, because that does not jibe with what I get. Let us just take New Jersey, for instance, which I am most familiar with, since I am a resident of New Jersey.

We now have 6,000 fewer hard core addicts who we cannot treat today in New Jersey than we were treating in 1980. We now have waiting lists to get into rehabilitation centers that range anywhere from 6 weeks to 3 months. In many instances, there are hardcore addicts who are out in the streets committing crime because we cannot reach them to pay for their habit.

And we have had other witnesses from the States before our committee, and we have talked to a number of States about their problems, and it does not jibe with that.

For instance, in New Jersey, we know that in order for us to avail ourselves of the TASC program, the treatment of addicts and street crime program, which I am sure you know has been very, very successful, we have got to have a place to send people who need help that want help, or where a court indicates that that individual should be receiving some type of either inpatient or outpatient assistance.

But our courts find that we cannot place many of these individuals because space is not available. Such treatment costs about $2,600 in New Jersey, and I think that that is probably typical of the costs to the States to treat an individual who has a drug dependency through one of these rehabilitation and detox centers as opposed to $15,000 or $16,000 if we have to incarcerate them, because the alternative is that we have to bust them again when they are out on the street committing additional crime. We estimate that there are 9 to 12 million drug related crimes in New Jersey each year.

Now that is happening in New Jersey. And my understanding from the testimony that I have heard is that it is being repeated throughout the country. That is just totally inconsistent with the suggestion that somebody is picking up the slack.

Dr. POLLIN. Mr. Hughes, the director of the State drug treatment programs in New Jersey, Mr. Richard Russo, is someone whom we have worked with for a long time, and someone whom we have the highest regard for. He has previously been a member of our National Advisory Council.

And we take Mr. Russo's summaries of the situation in New Jersey very seriously. As yet, we have not had an opportunity to compare what has happened in New Jersey with the overall national trends. It is clear from the national data that on a national basis, contributions from State governments to drug abuse funding increased from $133 million to $165 million between 1980 and 1982. Private sector funding increased from $37 million to $60 million——

Mr. HUGHES. Let me just interrupt you. That is true, but it does not fill the gap. We have gone from $600 and some million down to about two thirds of that, down to about $430 million requested, and $260 if in fact it is signed in the legislation. And those figures that you are reciting are accurate, but it does not anywhere near fill the gap in some States like New Jersey, and like New York, I might say.

I was just supplied with the figures from New York. And I have not seen the exact figures in the past, but they jibe with my perception. New York State has gone in the 1980–81 fiscal year from $31.6 million, down, to in this fiscal year they have committed $14.8 million.

Dr. POLLIN. Mr. Hughes, we would very much like to sit down with you and with committee staff and go over these figures in detail. I know that we cannot do that given the time constraints of this hearing. The overall figures that you are citing, I think, are the overall figures of the total alcohol, drug abuse, and mental health block.

We need, I think, since I am convinced that we are both striving toward the same goal, to try to compare these figures, to reconcile them, and to see what the central core of truth is.

We are concerned at NIDA that the administration budget for drug abuse insofar as it pertains to prevention, communication, and research funds was cut in the House by approximately 9 percent at the same time that funds for other categorical health areas such as those at NIH and mental health in general were increased by approximately the same percentage.

Some part of that cut was restored in the House-Senate committee. But nonetheless, the House itself did not go along with the administration's request with regard to the sums that were requested in the President's budget for many of the very important functions having to do with monitoring the drug abuse trends, research, prevention, and communication.

Mr. HUGHES. Let me just, if I might, correct the record. I am in error in the amount committed by New York State and the increase in Federal funding.

Mr. Chairman, with your permission, I would like to submit this for the record, which indicates the decreases in Federal funds and the modest increases.

Mr. HALL. It will be made part of the record.

[The document referred to follows:]

Federal drug abuse funding to New York State

	Million
1980–81	$31.6
1981–82	28.9
1982–83	24.5
1983–84	14.8

Note.—The State's share has increased from $61.5 million for 1980–81 to $80.4 million for 1982–83.

Mr. HUGHES. It indicates that actually they are not really dealing with the problem if you give effect to inflation.

There is one additional suggestion made in your testimony that 90 percent of the use reduction in this country is due to supply reduction. And I wonder where you get that data.

Dr. POLLIN. I am talking not about 90 percent of the actual reduction, but 90 percent of what in our view would be the level of use if we did not have the totality of our present supply reduction efforts. The data comes from our conclusion that given the properties of cocaine, if cocaine were as easily available as our two major current licit drugs, cigarettes, and alcohol, we conclude that there would be as many users of cocaine as there are of nicotine and alcohol.

But in point of fact, instead of there being 50 to 100 million users, which is the range of users of cigarettes and alcohol, there are only 5 million current users of cocaine. And the only explanation for that substantial difference that we can come up with are the effects of the totality of our legal system and our supply reduction efforts.

Mr. HUGHES. I really do not follow that. I do not see how you can make that connection. You say that you have ruled out all other variables?

Dr. POLLIN. Now that is a matter of judgment. It is not the kind of question that can be put to empiric test. We really cannot set up a system where we make cocaine that readily available. But based on our knowledge of the drug, its appeal, the perception of its health hazards, free availability of cocaine in our view would lead to a tremendous increase.

Mr. HUGHES. Mr. Chairman, may I have 1 minute. I realize that I have gone beyond my 5 minutes. Just one more question.

I understand, and I listen here to your testimony, that your testimony is that, in essence, the supply of cocaine is leveling off in this country?

Dr. POLLIN. No, not the supply. We think that the supply might actually increase. But despite the increased supply—and as with marihuana there has been an increased supply during the last five years—actual use in terms of overall use levels, total number of people using has leveled and has come down.

Mr. HUGHES. And where do we get that information, on what do you base that?

Dr. POLLIN. The confirmation comes from a variety of different national surveys supplemented and confirmed by individual State surveys.

Mr. HUGHES. Well, that does not jibe with any of the testimony that I have seen, and the Subcommittee on Crime has had extensive hearings as well as the select committee. And my own perception is that we are loaded to the gills with cocaine, and the use is up. You talk to any police officer in any major city, any social worker in any major city, and the fact of the matter is that we are loaded with it, and the use is up.

Even though the use of marihuana may be declining, it is because the drug of choice has become cocaine and less marihuana. The price of cocaine is down, the purity is up, and our police departments cannot keep up.

Dr. POLLIN. Mr. Hughes, we are aware of the fact that at the same time that the total number of users in the country, which is a very important measure, is decreasing, that when that user population is as large as 5 million, subgroups among that user population can substantially increase their level of use, the potency of the drug they use may increase as well.

So the two statistics are not incompatible. You have a decrease in level of overall use in terms of numbers of users in the country. But within that still sizable pool of people who are using, the amount that they are using may increase as the price comes down. That is our best interpretation of the current situation.

Mr. HUGHES. Dr. Pollin, and this is my last statement, I do not believe any of those statistics. I do not believe them for one minute. Any more than I believe that only 10 percent of marihuana is grown domestically. I think those statistics are really, basically, worthless at this point.

Just like the statistics that we find in South America on how much marihuana was grown on the north coast of Colombia. We flew over more marihuana being grown than they estimated was produced in a given year in Colombia. Those statistics in my judgment are of very little assistance to us at this point, because our methodology and our commitment to try to get the kind of statistics that are needed are inadequate and just the hopelessness of the task really makes them essentially unreliable.

Dr. POLLIN. Mr. Hughes, I would welcome an opportunity to meet with you and/or your staff, and to provide substantial additional detail as to the methodology, the many, many approaches to obtaining these kinds of statistics which we have tried over the past 10 years and discarded, and why we are convinced that these statistics, when properly understood and the limitations understood, are very reliable and, in the range of general statistics available in health areas or social problem areas in this country today, will rank with the most reliable statistics currently available.

Mr. HUGHES. Thank you.

Thank you, Mr. Chairman.

Mr. HALL. Thank you, Dr. Pollin. We would like to ask that our staff and your staff get together on any of the problems that might have been mentioned here today. We appreciate your being here. Thank you very much.

Dr. POLLIN. Thank you, Mr. Chairman.

Mr. HALL. Our next witness is Mr. Tom Pauken from Dallas, Director of ACTION. Due to the time limitations and the number of witnesses that we have, we must stay within our 5 minute limitation on questions.

So at this time, we would ask Mr. Pauken if he would proceed. Tom, we are glad to have you.

TESTIMONY OF THOMAS W. PAUKEN, DIRECTOR, ACTION

Mr. PAUKEN. Thank you, Mr. Chairman, and members of the committee.

I would like to ask that my full statement be submitted for purposes of the record.

Mr. HALL. It will be made part of the record.

Mr. PAUKEN. I will try to summarize as briefly as possible, because I do understand that there are a number of witnesses, and there are time constraints on the hearing today.

I do think it is important to mention two things that have come up this morning. Mr. Bennett, who was here earlier, made very eloquently, two particular statements that struck me.

He said that people in America are turning their backs on drugs, that is what we need to see. He went on to say that we have got to "stop people from consuming".

I could not agree more, and that is really the direction we are taking at the ACTION agency, which is the Federal agency designed to encourage volunteerism. Mr. Hughes was talking a few moments ago about the issue of cocaine and marihuana.

I remember first getting involved as an attorney in the mid-1970's in the issue of drug abuse, because I saw many young people coming into my office in trouble with the criminal justice system. Time after time after time, it was either a drug-related offense or an offense that was caused by drug dependency.

I saw a lot of lives being destroyed, a lot of families terriby distraught, and unable really to do much about it at that point. I think drugs were one of the biggest problems that we faced as a society in the mid-1970's. Frankly, I did not know much about marihuana or cocaine. I am part of that generation in the late 1950's that missed it, if you will, while growing up in high school in the late 1950's and college in the early 1960's. Nevertheless, I saw so many of the self-proclaimed experts from some of our finest universities, and even representatives of the Federal Government at the time saying do not worry, marihuana and cocaine are no big problems. You can feel good with no or minimal negative health consequences.

I would suggest that one of the greatest changes that is taking place in America today, particularly under the leadership of President and Mrs. Reagan is the idea of no use of these drugs, rather than the sort of irresponsible ambiguous message that we saw in the mid-1970's, which in my judgment confused a lot of young people, who simply were not aware of the pitfalls and health consequences of the particular danger of the drug culture.

Mr. Rangel, the chairman, was talking earlier about cuts in funds or the administration not doing enough. I would like to point out that I inherited an agency, the ACTION agency, which is the Federal agency designed to encourage volunteerism. Under my predecessor it had done absolutely nothing in this entire area of drug abuse.

One of the first things that I asked our policy people to do was to go out and identify the leaders in the parent movement and other worthwhile efforts and to try to do someting to support their effort to educate the parents of this society and the young people of this society, to start doing something about the dangers of drug abuse.

In terms of 1982, 1983, and fiscal year 1984, proposed funding including our discretionary grants which are very limited in our agency, and including volunteer service, such as, older American volunteers, young volunteers. VISTA volunteers in support of the antidrug campaign, we estimate that the value of those dollars is approximately $7 million in each of those 3 years.

So we are pleased that an agency which had done nothing to next to nothing in this area before is very actively involved in the critical area of doing something about demand reduction.

With that in mind, I want to mention just a few specifics, I will not go into great detail, again considering the time limitations. In March 1982, we sponsored the first White House briefing on drug use in the family, which was hosted by Mrs. Reagan.

In this briefing, we put the issue of drugs and kids on page 1 opening up a host of efforts across the country. It was attended by corporate amd religious officials, government officials, representatives of civic and volunteer organizations, parents, and parent group leaders, media, and leading entertainment figures.

I would like to mention, and I know that Joyce Nalepka is testifying later, that the principal spokesperson that day were leaders of the parents movement. Because in our opinion, these are the people who got involved because they saw what was happening to their kids. They are the people who helped make that change, the change of attitude away from the cultural changes that began to develop in the 1960's that have so encumbered this society in terms of a lax attitude towards drug abuse.

So we felt that it was important that they be the spokespersons in order to let people know what the problem was and what could be done about it. Because as Mr. Hughes suggested earlier, the problem is so awesome and so significant, at times you almost want to throw up your hands, and say there is nothing that you can do about it.

But we had people like Jack O'Brien, who is the president of McNeill Pharmaceutical, who heard the parent leaders, and, thereafter, agreed to go out and sponsor in conjunction with ACTION a program called pharmacists against drug abuse.

Interestingly enough, coming over here this morning, I heard an advertisement by People's Drug Store updating their effort to combat drug abuse. But in the pharmacists against drug abuse program, 65,000 local pharmacists will be serving as libraries on drug information, distributing hard hitting, easy to understand literature about the kinds of drugs that young people use.

We have that material available. I know that we have provided that to the staff. We would be happy to provide that information to any members of the committee who would like to have that. We are very pleased that Michael Landon agreed to serve as the chief spokesman for this program.

We believe that the concept of pharmacists getting involved, and that of material being available to young people and their parents is a significant factor in trying to do something about this problem. Because I am convinced, and Dr. Pollin alluded to it earlier, that if young people realize the negative health consequences of getting involved in the drug culture, that will have the most significant impact in discouraging them from that initial involvement.

To that end, we provided to the parent leaders throughout the country up-to-date packets of materials with the latest scientific information on marihuana and on cocaine, which Mr. Hughes was talking about earlier. We think it is an excellent but basic pamphlet about the negative consequences of cocaine, as well as providing some questions and answers on the subject.

Again, that information has been provided to the committee, and it is going out to parents groups throughout the United States.

We recruited other public figures in addition to Mr. Landon. Melissa Gilbert, Gavin MacLeod, Jill Whalen of the successful program Love Boat are involved in making presentations to youth groups and parents groups around the country.

I do not mean to suggest to the committee its business, but I really do believe that at some point representatives of the entertainment industry, should testify before this committee, if they have not already been invited to do so.

You can do everything in the world to try to educate young people and their parents with good scientific information. But what is terribly distrubing to me is when I see some popular films playing up the drug use lifestyle, that does more damage, and it undoes so much good.

And I think that the entertainment industry has more of a responsibility than just to make a buck. They have a responsibility, really, to police their own people and their own industry. Particularly when major studios are, if you will, producing and distributing prodrug kinds of films. I think they have a responsibility to be held accountable, and to be questioned in terms of why they allow this practice to continue.

We are very encouraged with the fact that a major national fraternal organization, the Elks, with 1.6 million members have launched in conjunction with our agency a major national drug abuse campaign. This Saturday we will be involved in a training session with many of their State leaders.

Training sessions will be going on throughout the United States. They will be linking together with the parents network in a major effort to try to do what they can to help at the local and State level in this all important area of trying to do something about demand reduction.

We additionally awarded a host of drug prevention grants to organizations such as PRIDE, the Parents Resource Institute for Drug Education, in Atlanta which has done some tremendous work in this area. We have helped them in providing a toll free drug information number which is now available to people throughout the United States.

I know that Sue Rusche of Families in Action has testified previously. We have supported their efforts in terms of providing updated drug abuse information to people and to libraries throughout the United States.

In addition, we are trying to support State networks of parents in States such as Ohio, California, and throughout the United States, which are trying to band together in order to organize parents groups to combat the dangers of drug abuse.

In Bronx, N.Y., we provided a grant of $51,000 to a wonderful program called DARE, the Drug Abuse Rehabilitation and Education Program of the Catholic Archdiocese in New York. For the second year, we helped them sponsor a number of programs. In addition, they have an annual minimarathon in which runners, most of them young people, run through the streets of the Bronx bearing the message that drugs defeat people, and help grind them under the heel of poverty, that drugs are the enemy of their future.

Last year, 1,000 young runners participated in the marathon bringing the message to thousands of other young people. The project additionally is training 1,000 community leaders in a 10 county area, and over 6,000 other community activists, to try to help in this critical area.

Again, I will not go through the lengthy list of individual grants, all seed money grants, to what we consider worthwhile effective forces that are out there in the community at the local level to try to help in this absolutely critical area.

As a parent, I am very concerned about what is really the loss of a tremendous number of a generation. I think that it is particularly destructive to people in a low and lower middle income economic background. As an attorney I saw so many kids pass through my office who really lost their future because of their drug dependency and their drift into the drug culture.

I would only say that it was a cultural change in my opinion which got us into this mess. It is going to be a cultural change which ultimately gets us out of it. I happen to be one who supports very avidly the supply side economic principles of this administration.

But with respect to the drug issue, I personally believe that fundamentally the issue is as Mr. Bennett said earlier, the demand side. And it is not a Republican or Democrat problem, but it is a problem which affects us all, and it is a problem of trying to change attitudes and change lives.

I want to see my kids, and my oldest is now 8, when he becomes 12, or 13, or 14 to be back in a period of time when among their own peers they will have grown up in an atmosphere in which doing drugs was a dumb thing.

And I think that with the leadership of this committee, and the administration, and the tremendous work of the parents movements, and the State and local agencies we can see those trend lines that we have had really accelerate downward rather than simply stall and go back upward in the years ahead.

Thank you, and I would be happy to respond to any questions that you might have.

[The prepared statement of Mr. Pauken appears on p. 325.]

Mr. HALL. Thank you, Mr. Pauken, for your very splendid presentation.

Are you consulted on the making of Federal drug policy?

Mr. PAUKEN. Yes, Mr. Hall. We had two representatives from our staff who participated in the initial drawing up of the drug strategy. Our emphasis is purely on the educational and prevention side. We have no pretensions in being expert on the treatment side or the research side. So we limit our involvement there.

But we participated in that initial program. And I work on a regular basis with Dr. Turner, who is the White House drug abuse coordinator.

Mr. HALL. Do you have any suggestions on ways to reduce drug abuse in our schools and in the work force?

Mr. PAUKEN. Well, I know that Father McVernon is testifying today and he has done a tremendous amount of good work in the work force, and I think that he is as knowledgeable as anyone around in that area.

In terms of the schools, I really do believe that up and down the line, we have got to take a very tough line. I am not talking about throwing the key away, and putting kids in jail for first offenses. But, I am saying that we must take a tough line with regard to no use of illegal drugs, and let young people know marihuana is not harmless.

As Dr. Pollin said earlier, it is the gateway drug. Kids do not start on heroin. They generally begin with marihuana. And I think that the more information that comes out on marihuana and cocaine, which were depicted too often in the past as relatively safe drugs, the better it will be.

I was happy to see, I noticed that there was some discussion of New York, for the chairman mentioned speaking to Wall Street brokers. Well, there was an excellent article in New York Magazine last year about what cocaine did to one man's life.

This has to be out there. Because the more information that is there, I think the better the opportunity to make a difference. But I do think that we have to be very careful about the literature that is circulated in the schools. Because there are still a lot of responsible use messages that are going out.

I know that we are very careful in the literature that we endorse and that we support. I think that the school systems and State and local communities should be equally careful. The message should be very firm—no use.

Mr. HALL. What is your opinion on the establishment of a drug czar?

Mr. PAUKEN. Well, I really would defer to Dr. Turner's position on that. I just know that we are given our task, which I really initiated on my own, concerning the education and prevention side. I really do not have any personal knowledge to be able to make a judgment one way or the other on the drug-czar issue.

Mr. HALL. Mr. Oxley.

Mr. OXLEY. Thank you, Mr. Pauken. I, too, appreciated your comments and your testimony. I thought that it was excellent and very well prepared.

It occurred to me that as you spoke that one of the things that we found in holding a hearing in my district last year on the drug problem in the schools was that people were thirsting for information and knowledge about success stories.

They wanted to know that someone had broken the ice, and had indeed been successful in either a parent program, or through the schools, or through your organization, whatever it may be. They were interested in knowing that their efforts given the right direction would in fact be successful.

And I think that the important thing, as I know you recognize, is that we do show people that through their efforts they can be successful. It is so discouraging sometimes. When I talk to many parent groups back in my district, have to almost stroke them to the point where they understand that they are not just digging themselves in deeper, that indeed they can make a significant contribution.

And I was so pleased to see the statistics that Dr. Pollin gave us and the charts. I guess that I would have to disagree with my friend from New Jersey, in that I do see some positive signs. And those positive signs, it seems to me, is really your chore here, and you have performed very, very well in that area.

That is not necessarily a question, but just a comment. I do think that so many times we tend to work on the negative, and not really emphasize the positive responses that many people have come up with, and there are some very, very positive success stories that all of us can point to with pride.

Mr. PAUKEN. Well, I think that your point is well taken about the kind of lonely feeling out there by people trying to do something and feeling that they cannot make a dent. I would like to convey to you that 2 weeks ago I was in California, which as Dr. Pollin said earlier is about as tough a State in terms of this issue as anyplace in the country, and there were nearly 500 parents who had gotten together in the first statewide conference ever.

The attorney general was there, the Governor's office was there, the State drug abuse office was heavily involved. There was tremendous coverage from the media. There was a good feeling on the part of the parents who had been in it almost alone for a number of years, to be able to get a little support. We provided the seed money, so that that conference could take place.

And they are going from that State organization, parents finally coming together and saying that they are not just one or two, but that they are many, and that they are going back now to their local communities.

We are going to see, in my opinion, a real surge of parents groups developing out there. In addition, a number of starts from Hollywood are coming forward, and either talking about their own problem that they had, or problems of their friends, as well as their understanding about how devastating drug use is in their industry.

I think that you are absolutely right, and I am seeing some encouraging signs. The lady who ran that program said we could not have done this 2 or 3 years ago. There is a changing attitude out there, and a willingness of people to get more involved.

But I think that it is so important that we do not lose the momentum now. The momentum is running for the first time in a good while in our favor, and let us keep it going.

Mr. **Oxley**. Just one other comment, and perhaps you would like to comment, also. There is no question that the role of sports figures in this country is a significant one in terms of, particularly, kids looking up to them. We just had a reception the other night for Johnny Bench that was put on by the fellows who represent the Cincinnati area.

The popularity of someone like Johnny Bench is immeasurable. My son wanted to come down to meet him. It is just a natural thing in our society. And it seems to me that the sports people are in the same category as the entertainment industry, as you mentioned.

And I think it is important that sports personalities begin to recognize their real force for good when they want to achieve it. And I think that we should continue to encourage again, the positive side of that, because there is so much negative publicity in sports. "60 Minutes" did a thing about it the other night. It always seems to be the negative aspect that is stressed with sports figures.

And yet there are a lot of success stories. There are a lot of popular athletes who have never used drugs. And it seems to me that our efforts should be encouraging those kinds of people to be more and more aggressive, and to be more and more comfortable with their status in providing a positive image to the young people.

Mr. **Pauken**. A number of sports stars are getting involved in that effort. I know that my son who is 8 idolizes Joe Theisman. He used to be a Dallas fan, but I think that Washington and the kids around him with their "peer pressure," to use a term that is often used——

Mr. **Hall**. I wish you had not said that. [General laughter.]

Mr. **Pauken**. I know, I have got to get him back to Texas. But interestingly enough, Carl Eller, who had a problem of drug abuse, was just in Alexandria the other day speaking to young people and telling them what it did to him.

Coming from Dallas, I saw at a talented linebacker like Thomas Henderson just throw his career away with drugs. It is really a very tough situation. I am very glad to see that the leagues of baseball, basketball, and football are beginning to get tough.

I know that in Dallas, they brought in a special individual because of their concern this year about the problem. We were out in California with Tommy Lasorda and I learned that a man had been brought aboard the Los Angeles Dodgers organization to try to help in that area.

I think that all of the leagues need to make the lines very clear. For awhile even in sports, I think that there was an excuse for that behavior, because of the desire to win. I think that they have to make the rules clear and firm with regard to athletes. Because they do affect young people, and there are a great majority who are doing wonderful things out there, and that needs to be given greater emphasis, too.

Mr. OXLEY. Thank you.

Mr. HALL. Mr. Hughes.

Mr. HUGHES. Thank you, Mr. Chairman.

And I, too, want to commend Mr. Pauken on a very, very fine statement, one of the best statements that I have heard in a long time. I think that it was wellbalanced, and I commend you for it.

I want to say to my colleague from Ohio that I did not mean to suggest that there are not positive signs. On the contrary, I see a lot of positive signs. What I was quarreling with was some of the data that was advanced here that would suggest the incidence of use is declining. I do not see that, and that is what I quarrel with.

And I quarrel with the suggestion that we can do more with less. That we can go from $630 million down to $430 million, and expect the States and other organizations, in this economic climate, to pick up the slack.

I also quarrel with the suggestion that the Federal Government does not have a lead role. This stuff is not grown mostly in our area. It comes in from outside of our borders. It is a national problem. It is a national problem that we have to deal with.

The States are not able to deal with it, we must be full partners with the States in dealing with what I consider to be the most serious national problem that faces us domestically, the drug problem.

I was privileged to be with Ben Gilman about 1 week ago to view the "Chemical People," an excellent television program. And the First Lady has done an outstanding job, and she has provided great leadership. She is to be commended, along with Michael Landon for his work, and all of the others associated with that program.

I think that the parents groups around the country are doing a great job in identifying the problem, and working with families and trying to deal with the drug problem.

I have had inquiries from corporations who want to know what they can do. Sears & Roebuck in the past few weeks has written to me. And I suggested that a good program for them would be one that involved education, to work with the experts in trying to get a message out to the people.

I still see a lot of areas where we can improve. In the schools, there is not the information that ought to be available. As my colleague from Ohio says, they are thirsty for information. I visit the schools probably as much as any Member of Congress. Anytime I have a free morning, I will stop at one of the schools and talk to them.

There is a great deal of misinformation. And I find that unfortunately there are not anywhere near enough programs in the schools. We are not reaching particularly the kids in the lower grades.

The testimony before my committee just a few weeks ago was that if we do not reach them until they are juniors, you might as well forget about it. The damage is already done. You have to reach the youngsters in the fifth and sixth grades, and deal with it at the level, and tell them how wrong and how bad for them drugs are.

We are not doing that, really, on an organized basis around the country. I was surprised to learn that it is not just hard-core drugs, and it is not just the marihuana that we should be concerned about. I was surprised to learn about the link between cigarette smoking in the grade schools and the incidence of marihuana use.

The incidence is very high among those who are smoking in the schools. So we have to deal with that problem. So you are right, there are signs that I think are healthy, but unfortunately we have not yet made the commitments that are needed.

Even though I spent 10 years in law enforcement, I have come to realize in the last few years that it is the demand-reduction side that we have to deal with. So I agree with you. On balance, I think that is where we have got to commit more resources.

Mr. Pauken. And, also, Mr. Hughes, as you say, in the schools, I guess that I was really struck when I came into ACTION and looked at some of the materials that were going out to the schools, and which still are out there, which had these mixed messages; very ambiguous messages with regard to marihuana use, as an example.

I think that in addition to having programs, it is the substance of the programs that is so critical. We have put together pamphlets entitled "Marijuana and Alcohol Combinations," "Marijuana Goes to School," and "Cocaine, Some Answers and Questions."

There is nothing fancy about them, but the information is up to date. They are solid, and they are firm, and they are clear. And I think that if kids read them, and their teachers are able to communicate them, that they would be very helpful.

This is not something that the Federal Government really can police. Because your State agencies, your local communities, your local school boards, and your local parents have to take a look at the materials that are being circulated in the schools, and say: "Hey, is this the kind of message that we want the kids to get?

"That it is OK to use marihuana as long as you do not use it to a great extent?"

Mr. Hughes. I agree that the Government has to provide leadership. The Government has to provide leadership and resources.

Mr. Pauken. I can only say in response to that, that the California group was so pleased with our grant, which was not a big grant, because nobody had ever given them any financial support to allow them to pull together a statewide program.

And that little bit of money directed to the right people and in the right fashion is making a big difference. That is what we are trying to do—target the money to some of these really good parent groups that are out there and support their initiatives.

Mr. Hughes. The crime subcommittee had testimony from two youngsters from Straight, Inc., which is in the drug-rehab area, as I am sure you well know.

Mr. Pauken. I am familiar with it.

Mr. **Hughes**. And they have a facility in Florida. I was impressed by the testimony of those youngsters. And the one thing that I think they pointed out very vividly is that they can do a better job of reaching their group than you or I can, in the schools in particular.

Mr. **Pauken**. I agree.

Mr. **Hughes**. And we are not using that resource. I am wondering if you have any suggestions on how we can advance that program. Because for a youngster to get up before a class of his peers, and say: "Look, I have been through it, and it almost killed me. I want to tell you when they tell you that marihuana is not bad for you, let me tell you that today I am in the poke because of that," that is effective.

Mr. **Pauken**. Yes, absolutely. I think that you have hit on the key. Ultimately, it was the peer-group pressure. I remember representing a young man on a drug abuse first offense, and we got him probation, and his parents were really happy. I explained that if he just served out his time on probation, that it would be wiped off his record.

And his parents were relieved. I went on to say that now, of course, you know that you cannot be arrested and charged with another offense, because you run the risk of having probation revoked and serving some time in the county jail. And he was all upset, and I could not understand. Because his parents were relieved, and I thought that he would he happy.

Finally, I said: "What is wrong?" And he blurted out if he did not do drugs, he would not have any friends. There is that kind of enormous peer pressure. He was a nice kid; he was not a leader.

But it is so powerful out there. That is why young people can make a difference. We provided to the committee, and I will provide it to you, Mr. Hughes, through our Young Volunteers in ACTION program, an idea exchange on how young people can get involved in a drug-prevention effort.

We are funding a number of young volunteer programs. Also, Big Brothers and Big Sisters programs and DARE, which is young people helping other young people in New York in the drug-abuse area. Also STRIDE, and PRIDE, which I mentioned is a group that we are funding out of Atlanta, now has a young person on board to help organize other young people to, if you will, encourage reverse peer pressure.

So that we can get back to the time that I was talking about when we were growing up when drugs were a dumb thing to do.

Mr. **Hughes**. You have put your finger on something that I agree with wholeheartedly. We have permitted too much tolerance for substance abuse in this country. We talk about users not really being too bad. But users are polluters. Users are ones who get others to use. We better start dealing with that problem.

There was something else that you mentioned that I could not agree with you more. Public officials, movie stars, football and baseball players, the role models, they are the ones that the courts should be dealing with very severely, particularly when they are involved with substance abuse, because they do more damage.

Just like the films that you mentioned which undercut our efforts. All the good that we do is undercut by one bad film that make a hero out of somebody who is involved in some form of substance abuse. So I commend you for it.

One last question that I have for you. I hear some suggestions that voluntary groups are spinning off, going off in different directions. And there is not really very much coordination, not very much contact with health professionals.

What do you have to say about that?

Mr. PAUKEN. Of course, Joyce Nalepka will be testifying later, and she could speak more directly as a leader in the National Federation of Parents for Drug-Free Youth. I think that you can run the risk—we try to, if you will, to bet on good people in good organizations, and let them really run with the ball.

And there is bound to be some conflict, and there is. But the key, if you can do it, is to try to get everybody together with a similar message, and coordinate efforts. In one instance I know of, for example, law enforcement officials had never sat down with the educators and the parents all in one room.

And once they sat down, they found that there was a lot of common ground there. So I think that coordination is very important. But I do not think that anybody can force that, whether it is a drug czar, or the Federal Government, or a bureaucracy, or an agency.

I think that has got to depend on local and State leadership to have that happen.

Mr. HUGHES. Thank you.

Mr. HALL. Mr. Coughlin is recognized.

Mr. COUGHLIN. Thank you, Mr. Chairman.

I join my colleagues in congratulating you on fine testimony. Without denigrating any part of the effort against drug abuse, I feel strongly personally that the kind of effort that you are putting forth is the most important thing that we do, because it gets the biggest bang for the buck in terms of combating drug abuse.

And I guess that it is interesting to me that we are making progress. I remember when I came on this committee, that we spent a good deal of our time discussing whether marihuana was harmful or not.

Mr. PAUKEN. Yes.

Mr. Coughlin. And we have had a considerable change in attitude over the years.

Let me just ask. You are operating now under a continuing resolution; is that correct?

Mr. PAUKEN. Yes, sir.

Mr. COUGHLIN. At a level of $4.7 million?

Mr. PAUKEN. Well, under the continuing resolution, our total budget at ACTION is approximately $130 million. But the discretionary money that we have totals $1.8 million. Over 25 percent of that we specifically put into drug-abuse-demonstration grants. And then we have VISTA, Foster Grandparents, Retired Senior Volunteers, Senior Companions, and Young Volunteers in ACTION, all of whom we have encouraged to get involved in drug-abuse efforts.

And they are helping, particularly the Foster Grandparents and the Retired Senior Volunteers with troubled youth, and in some cases in treatment areas.

One concern we do have is that last Friday, the House of Representatives, I am sure because the issue was regarding VISTA, put in a $25 million VISTA floor, which, if passed by a conference committee and the full Congress, would eliminate all of our drug-abuse moneys, because that would be more than our total amount of money in all of the various sections or parts that allow us any discretionary funding.

So we are concerned about the plans. We have plans to fund upwards of 15 to 20 additional State parent organizations this year. But if, through that action of the House, the VISTA floor prevails in conference, then that would all be eliminated. So we are hopeful that some kind of accommodation can be reached at the conference committee.

Mr. COUGHLIN. What is your budget request level for the drug abuse program?

Mr. PAUKEN. We have a discretionary total amount of $1.8 million, of which more than 25 percent is put directly into drug-abuse efforts. Then in addition, we have volunteers, and we relate the value of the volunteers, the Foster Grandparents, Senior Companions, Retired Senior Volunteers, VISTA volunteers, and Young Volunteers in Action, some of whom are involved in drug abuse efforts.

So our figures indicate the value of those dollars come to altogether nearly $7 million for 1982, 1983, and projected for 1984.

Mr. COUGHLIN. That is the budget request?

Mr. PAUKEN. If our continuing resolution were passed, that is what we would continue to do.

Mr. COUGHLIN. I am trying to find out the administration budget request.

Mr. PAUKEN. ACTION has a discretionary amount of approximately $1.8 million each year for all of our discretionary programs. Of that dicretionary amount, our policy is to put approximately 30 percent into drug abuse demonstration projects.

Over and above that, we have ongoing Foster Grandparent programs, the Retired Senior Volunteer program, the senior companies program, and the VISTA volunteers program. We encourage many of them to get involved in drug abuse efforts.

For example, in Alabama, we have 30 VISTA volunteers.

Mr. COUGHLIN. Excuse me, I do not mean to interrupt.

Mr. PAUKEN. I guess that I do not understand your question.

Mr. COUGHLIN. The budget for the drug abuse program, what did OMB allow you?

Mr. PAUKEN. Our part C demonstration money request to OMB is $1.8 million.

Mr. COUGHLIN. And that is what OMB allowed?

Mr. PAUKEN. That is what OMB allowed, correct. They allowed the full request. I apologize. I am sorry, I did not understand the question.

Mr. HALL. Mr. Rangel.

Mr. RANGEL. Mr. Chairman, I just wanted to apologize to your witnesses. Congressman Gilman and I were over at the White House when the President signed Dr. Martin Luther King's birthday into law.

And I heard the eloquent questioning from my colleague, Mr. Hughes. And I assume after talking to him, and hearing your answers, that notwithstanding the great work that is being done by ACTION and the President's wife, that you do see a need for there to be a Federal presence as it relates to treatment and rehabilitation on the local and State level.

Mr. PAUKEN. Well, my area is education and prevention. That is the area that we are involved in. I do see a need for our Agency to continue supporting the parents network that is out there. I see us really as a catalyst.

Mr. RANGEL. I thought that I had lauded the work that your Agency was doing. I just want to shatter the fears that some people may have that this administration believes that volunteerism is a substitute for a Federal presence with these local and State programs. And I know that that is not your position, and I support the great volunteer work that you are doing in education, getting parents involved.

And recognizing that as you do that, we will be fighting some of the severe and drastic cuts that our States have suffered as a result of domestic program cutbacks.

Mr. PAUKEN. Mr. Rangel, I remember watching you many years ago on a public television debate on the heroin issue. And that was at a time when some people were calling for legalization of heroin, and that was going to take care of it.

I think that one of the points that you made very eloquently that day was what does it do to the people who are caught up in it, it is very destructive. Legalization simply gives up on people and almost encourages them to destroy themselves.

Dr. Pollin earlier was talking in terms of the dangers if we move toward casual attitudes toward cocaine and marihuana. I truly believe, and Mr. Bennett said it earlier, that it was a cultural change that got us into this thing. We have got to have the cultural change to ultimately get out of it. And that is starting to happen.

Ultimately, it is not going to be Government which makes that cultural change, because it was not Government which got us where we are today. And that is why I am so committed to education and prevention. I do believe that we have a significant role in helping the leaders out there.

I call them the new counterculture, because these parent groups for a number of years were like voices in the wilderness. They could not even get into the doors of the White House.

Mr. RANGEL. How do you handle it, that after you have done an effective local job, and a parent does what you suggest and gets involved, and comes home and finds out that his 16-year-old kid is indeed involved in drugs, and is addicted to drugs.

Mr. PAUKEN. Sure.

Mr. RANGEL. You have done your job, now what is the next step?

Mr. PAUKEN. That child needs to be treated.

Mr. RANGEL. We have 1,500 people waiting in the city of New York for treatment. You may have overdone your job in New York State. These people are volunteering and asking for help.

I talked yesterday with Jose Julio Martinez. He has 15,000 people waiting for treatment in the State. So what I am saying is that this is a partnership. We have to lock up the traffickers. We have to prevent and educate people from getting involved with peer pressure. And we have got to provide some assistance for those people who want to get out of that.

Mr. PAUKEN. I understand. As I think I mentioned earlier in my statement, we make no pretense to being experts in the treatment area. But volunteerism, I think, can make a big difference in the education and prevention area. We stay away from treatment, though, because we are not experts, and we do not pretend to be.

Mr. RANGEL. I am just saying that the Federal Government has to be involved in providing assistance in this area, whether we are talking about law enforcement, education, and prevention. And the big gap that you are filling and so many other people are really filling, and people have to be involved, communities have to be involved, and we have to spend more time preventing it.

I agree with you. And when I call on you for budgetary support for NIDA, you be there.

Mr. PAUKEN. And when I call on you, Mr. Chairman, to remove that floor from VISTA, so that we can fund the drug-abuse projects, I sure would appreciate it.

Mr. RANGEL. I did not know that they allowed you folks to talk about asking for money. [General laughter.]

Mr. RANGEL. Thank you, Mr. Chairman.

Mr. HALL. Mr. Gilman.

Mr. GILMAN. Thank you, Mr. Chairman.

We certainly welcome you before us, Mr. Pauken. I am sorry that we had to be at the White House earlier, and was delayed in getting here.

Now I am very much appreciative of the efforts that you have awakened in the community, and in the private-sector community, and the voluntary community. And I am very much concerned at the same time about the limited amount of funding that has been earmarked for this kind of activity, some $25,000 for each State which you indicate in your testimony, which is a pretty meager amount of seed money out there.

Some $400,000 out of a $1.8 million, I think that you are talking about.

Mr. PAUKEN. This year it is approximately $560,000 out of $1.8 million projected for 1984, $575,000. But over and above that, we have VISTA projects and Young Volunteers in Action projects that target drug abuse.

Mr. GILMAN. But that is a volunteer here and there; is that not right?

Mr. PAUKEN. Not necessarily. In Alabama, we have 30 VISTA volunteers who are organizing low-income parents groups throughout the State. So it just depends on the individual project.

Mr. GILMAN. But for a nationwide problem such as we have, and I looked, for example, at the projects that you have in New York State. You have, I think, three projects that I note in your testimony.

Mr. PAUKEN. That is right.

Mr. GILMAN. For all of New York State, and you spend less than $100,000 in an area that is considered one of the most critical narcotic trafficking and abuse areas in the entire Nation. But that seems to be indicative of the limited amount of resources that have been earmarked for this program.

Mr. PAUKEN. Let me note again if I could, and I know that you had to be absent from my testimony, one of the points that I made, Mr. Gilman. The No. 1 personal interest that I had before I came to ACTION in February 1981 was in getting involved in this issue, and getting out people immediately upon my arrival at ACTION getting our people involved so that ACTION could take an active role in drug abuse, education, and prevention.

Mr. GILMAN. I appreciate that you have awakened the interest in doing that, and it is certainly a step forward.

Mr. PAUKEN. ACTION during the previous administration had done zero, no grants whatsoever. We have very limited discretionary funds. The $1.8 million, I agree, is not much. But it is much to us so that even when we make a $25,000 grant, we are very careful as to who it goes to, and we want to see that it really does a lot of good.

I cannot say that that is going to make an enormous amount of difference. But I can say that in California where a small grant permitted the first statewide conference, that was the first support that those parents groups had ever had.

Mr. GILMAN. This is a laudable effort, and we commend you for it. What I am saying is that there is an apparent need for a better job. What I want to know is if you have made a request for more funding in the coming budget.

Have you made a request for sufficient additional funding to reach out and do the kind of job that is needed nationwide?

Mr. PAUKEN. Well, we will be able to, if the situation which took place on the floor of the House last Friday is overcome, we will be able to be funding the great majority of parents networks statewide throughout the United States by the end of this fiscal year.

Mr. GILMAN. I do not think that you are answering my question.

Mr. PAUKEN. Did we ask for an increased amount; no, we did not, Mr. Chairman. Obviously, we are in the process of developing the final fiscal year 1985 budget. I happen to believe particularly in some of the larger departments——

Mr. GILMAN. May I interrupt for a moment, my time is running pretty rapidly.

Do you feel that the $500,000 is adequate enough to do what should be done by the volunteer groups out there?

Mr. PAUKEN. What the volunteer groups have told me is that they sure are appreciative that for the first time ever they are getting support from any administration.

Mr. GILMAN. Sure they are appreciative, but is it adequate to do the kind of nationwide job we should be doing to address a critical problem of this nature?

Mr. PAUKEN. I believe that once we have funded all 50 States in terms of statewide parents' groups throughout the United States, that the idea which we have developed, which is, to provide seed money to help groups get organized, put that State network together, that thereafter most of those groups will be able to raise money in the State government, the local governments, and the private sector.

Mr. GILMAN. Mr. Pauken, if I might interrupt.

Mr. **Pauken**. Yes, sir.

Mr. **Gilman**. Take New York State. There are several hundred volunteer community groups in the process of being activated.

Mr. **Pauken**. That is right.

Mr. **Gilman**. How far will $25,000 go in giving them some seed money?

Mr. **Pauken**. It would probably pay for a statewide conference to be organized.

Mr. **Gilman**. But they are organized, they are organizing. And if you are going to really help them, they probably need some material, and need some information.

Mr. **Pauken**. Sure, we have that. We provide the information which I spoke of in my opening remarks, which I think is some of the best and simplest, the most basic information, particularly on marihuana and cocaine, that is available. We provide that to parents groups throughout the United States, to individual parents groups in community after community.

Mr. **Gilman**. And I assume that you feel quite comfortable that the funding that you have recommended is sufficient enough to do the job nationwide; is that what you are telling me?

Mr. **Pauken**. That is not what I said, Mr. Gilman. What I am saying is that I think that we are doing a lot. I think that more can be done. There is no question about that. We have very limited discretionary resources. We put a substantial amount into this area. I am sure that there is plenty in the Department of Health and Human Services.

I think that if we target our money better, we would get a more effective bang for the dollar. When I see some of the materials that were sent out a few years ago on this drug issue, paid for by the Federal Government, I see it sending out the wrong messages. There may have been a lot of money spent, but it was spent, in my judgment, for the wrong reasons and with the wrong kind of information that did more damage than good. I think that with a few dollars that we are doing a lot of good.

Mr. **Gilman**. I hope that you will bear in mind that we are here to help you do even a better job, and we hope that you are not going to be meek about asking for the kinds of things that should be asked for to do a better job. That is what my intention is. And I do not think that you have enough resources to do what you should be doing out there nationwide.

Thank you, Mr. Chairman.

Mr. **Hall**. Thank you, very much.

Thank you, Mr. Pauken, for a very fine delivery, and making a very good contribution to this committee.

Mr. **Pauken**. Thank you, Mr. Hall.

Mr. **Hall**. next witness will be Mr. Kenneth Eaton, administrator for the Michigan Office of Substance Abuse Services, and chairman of the Legislative Committee of the National Association of State Alcohol and Drug Abuse Directors.

TESTIMONY OF KENNETH EATON, ADMINISTRATOR, MICHIGAN OFFICE OF SUBSTANCE ABUSE SERVICES, CHAIRMAN, LEGISLATIVE COMMITTEE, NATIONAL ASSOCIATION OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS

Mr. **Eaton**. Thank you, Mr. Chairman.

I will make a special effort in proceeding by adhering to your timetable. With your permission, I would like to submit the more lengthy statement for the record. And if desired, I would be prepared to submit additional information.

Mr. **Rangel**. That is very considerate of you, Mr. Eaton, and I accept your generous offer. Your testimony will be entered into the record without objection. I would like to say even before you testify, that we have to work a little more closely with your association, and find out what statistical data you have there on a statewide basis.

Because yesterday, we made an agreement with the administration that we would be bringing to it information on a State-by-State basis. Because there is a sharp conflict between what they say that they are doing, and what our State people are responding as to the need, so we will be working together.

You may proceed, thank you very much.

Mr. **Eaton**. Yes, sir. That contrast certainly does exist, and we have some concern about it, too. And we look forward to working with you about it.

To avoid repeating statistics about the nature of the problem, which you are already familiar with, I would like to cut through. And I have several questions of the same nature that the committee members had as we looked at changes in drug use trends.

It encourages us, of course, to continue to look at those and discover what they mean. Frankly, the answers make little difference to my conclusions. I still see a $220 billion a year economic cost related to substance abuse in this Nation.

Even if that is 15 to 20 percent wrong because of survey techniques, we have a bigger problem than we can tolerate. I still see this as a country in which our youth are engaged in the highest level of drug use and abuse than any other industrialized nation in the entire world.

I know that we still have a great many heroin addicts. And that each one of them after pursuing their addiction commits something in the neighborhood of 300 to 350 crimes a year. I really do not care if that statistic is 20 percent wrong, because it is still a tragedy no matter what the average statistic is. I know that one-third of the prisoners in our prison system in 1979 were under the influence of an illicit drug when they committed the crime for which they were incarcerated.

And again, I do not really care if that is 20 percent wrong or even 25 percent wrong. What it means is that we have prisons throughout our Nation full of people who have committed their crimes while under the influence of illicit drugs.

It is clearly a major problem, whether it is getting a little bit better now, or whether it is not. I hope that it is. I am very pleased to see, and I agree that we are seeing some changes in our State about the use of statistics.

It is unfortunately not really showing up yet in problem statistics. We do not see it yet reflected in any change with respect to demand for treatment. Someone mentioned some things that were going on in the State of New York, where according to the information that I have, and we all try to work fairly closely together, we were looking at something like a 500-percent increase in the demand and need for treatment for cocaine abuse in the past 5 years.

Something very similar to that with respect to cocaine has happened in Michigan, especially in Detroit where we have seen the demand for that treatment double only in the past year. It is true that opiate admissions are proportionately going down slightly. That speaks mainly for heroin.

The downtrend is from about 15 percent in 1979 to about 11 percent of all of the admissions in our treatment system in 1981. We like to see that, but on the other hand, we still see within the city of Detroit, our major metropolitan area, that 30 percent of all of the treatment admissions in the entire substance abuse service network are for heroin addiction.

We see narcotic deaths dramatically increasing for reasons that I am not certain how to explain. The increase is dramatic! From 1978 to 1982, we saw about a 150 percent increase in narcotic deaths in the city of Detroit.

Dilaudid and cocaine are also going up. I will not continue to go through the trends. I am sure that through the very excellent hearings that the committee has held over the past year in different parts of the Nation, you are as familiar as we are with the nature and scope of the problem. Many of my colleagues have participated in these hearings and we are anxious to continue working with you.

The issue now is what to do, where to go from here. I would like to make one remark about money, but prefer not to focus on that. With respect to the block grants, I have a relatively simple way of dealing with that issue. And, of course, we will share whatever information we have about the States collectively, or about any individual State you might wish.

I do not see any way to avoid the fact that there is about $95 million less in the substance abuse block grant in 1983 than there was in 1980. I learned that type of arithmetic in the fourth grade, and I have not forgotten it yet. I can subtract $332 million minus $237 million, and I come out with that number.

I see it more vividly, however, as my colleagues in other states do. I see it this way. During the year that that cutback came, I remember quite vividly reviewing about 252 pieces of paper. These pieces of paper represented the contracts between the State and the local service programs that were providing substance abuse services.

And in those 252 pieces of paper, I was telling the program directors, the people providing those services, that they were going to have less money in that coming year. And in 59 pieces of paper, I was telling those programs that they would not just have less money, they were going to be closed. The program would not even be able to operate, because the level of funding had decreased so much.

Then about a year later, I see it again in paper. I am a bureaucrat. I have to deal more with paper unfortunately more than I get to deal in human terms. This paper reports that we provided treatment services to 10,000 fewer people in the State of Michigan for their substance abuse problems than we did the year prior to the cuts.

Now that is my reality, and I think that that is the reality of people who are in your cities and in our States attempting to keep a service system alive, dealing not only with treatment, but also prevention services, and trying to cope with what has happened here.

Again, I would not quibble about percentage points, because it still means the same thing. Those 10,000 human beings are the important issue. Even if we can find a way to juggle accounting systems, or allege that the private sector is expanding, we still lost those 10,000 people.

I, unfortunately, cannot tell you where they are or what happened to them, because we are not even able to keep track of them. I would urge you to keep your attention on that human factor.

We reduced our programs by about $3.7 million. The State of New York reduced it more, and many other large States did even more than that. At the same time, we brought about 10,000 more people who were unemployed in our treatment system. Their insurance was gone, or what little insurance payments were available could not be made available for that purpose.

So I want to urge you to consider the fact that the States do need more help in this respect. The State legislatures are not able to fill this gap. Their economic circumstances simply are not strong enough. And in many cases, their political stability is not strong enough to appropriate State funds to pick up these gaps.

So please let us not fool ourselves into thinking that somebody else is busy filling up the gaps. There is growth in the private sector, and I am pleased to see that. Quite frankly, most of that growth in the treatment system is in private acute care hospitals intended mainly for middle class alcoholic people.

I am very pleased to see that. But those treatment programs paid for by the private sector are not going to touch the inner city hard core addicts of this Nation, It is just not the type of system that is going to reach them.

I would like to make a point about the demand and supply issue, too, but in a slightly different way. I am not sure that there is a proper favorite theory about whether supply reduction is better than demand reduction. I think there needs to be a balance.

And traditionally, there has been a better balance between the Federal Government's ability or efforts to deal with those two compared to each other. In recent years, we have seen a shift in that. It has not been a very large shift, but it has been very important.

Let me give you some examples. In the law enforcement area, and the big bulk of these expenditures are for interdiction services—that is to keep drugs away from our boundaries, 1980 the Federal budget was about $537 million. In 1983, there is $695 million. That is a $158 million or a 30-percent increase in the law enforcement efforts, or the efforts to reduce the supply.

On the demand reduction side, the prevention and treatment, we went from $332 million in 1980 down to $223 million. This is roughly a $110 million or a 30 percent reduction.

In summary, while we were increasing our efforts on the supply side efforts by 30 percent, we were at the same time reducing by almost an equivalent percent, the activities in which the Federal Government was participating to help the demand side reduction, that is the prevention, and education, and the treatment side.

In 1980, those demand side efforts represented about 38 percent of the grand total. This year, they are going to be below 25 percent. There was a relatively strong signal in the Federal drug abuse strategy that this was going to be the case.

I suggest that we review that very, very carefully. Not so much to take a favorite theory approach of demand reduction versus supply reduction, but with the view in mind that we do need a balance. In my opinion, it is not properly balanced at this particular point.

I think that we are not taking advantage of what we have learned on the demand side, and that we need to devote substantially more resources to that.

I look sometimes at what we accomplished with so much effort on that supply side. I know that this is a bit simplistic. For that I apologize. But one of the major dynamics we are noticing, is that we seem to be moving bubbles. We stomp down on one place, and we will see the bubble come up someplace.

One of the most dramatic examples of this is in prescription drug diversion. Now these are not drugs that come in from South America, or the Mideast, or Mexico, or anyplace else. These are drugs that are manufactured by our own manufacturers here in the United States.

Annually, at least 310 million doses representing a cost on the street of over $3.5 billion are diverted from among the prescription drugs manufactured. I frankly think that estimate is low. Included were about 150 million doses from prescription fraud.

About 30 million doses are reported to have been stolen and diverted to the street; And about 130 million doses are diverted by health professionals for various reasons.

We pay for that in many, many ways. Prescription drugs are becoming almost the favorite drugs of abuse. Favorite over heroin, and favorite over other illicit drugs, perhaps the only remaining exception is marihuana.

More death and injury from the abuse of prescription drugs is now experienced than from the use of all illegal drugs combined. We pay in our medicaid program, we pay in our medicare program. In Michigan, for example, a sample group of known drug abusers who are also in the medicaid program were studied. In a 6-month period, this relatively small group of medicaid beneficiaries had received an average of 155 prescriptions each during a 6-month period. That is almost one every day.

We know that they are not using those. We know that they are being diverted to the street. I would recommend that this committee look carefully at the prescription drug abuse problem.

I know, Representative Hughes, that your committee had been looking at that matter, and I certainly commend you for that. I claim that it is one of the most rapidly growing drug abuse problems of our Nation.

We have reached a point that drugs like preludin, which can be purchased at the drugstore for about 22 cents a capsule go for $12 to $15 on the street, dilaudid which again runs about 20 cents per capsule in the drugstore and is selling for $20 to $30 on the street. This is providing a big incentive for organized crime syndicates to switch away from the very expensive activities of importing drugs from other countries. They have more lucrative alternatives right here at home.

I believe that a great deal of that has happened, and it is worth our looking at carefully.

In our health care industry, we are suffering, too. Substance abuse problems probably account for 15 to 18 percent of all of our health care expenditures. Unfortunately, it is not for good reasons. It is for reasons that people are sick and are in hospitals, but not receiving proper treatment for their substance abuse.

They may be receiving some detoxification service, or some service in our emergency rooms, but we do not follow up to provide the needed longer term treatment that can change their life styles and keep them out of our health care system.

The undiagnosed problems in chemical dependency are far more expensive than the diagnosed problems. Again, I would urge that you look carefully at the fashion with which our medicaid and our medicare program are not dealing today with the problems of substance abuse. I would be happy to work with you on this issue and provide additional information.

We are paying a great deal of money for hospitalization and for doctor fees for these people. As a group, they demand about eight times more health care utilization than people who receive proper treatment. So they are expensive. We are not dealing with them properly. We are spending a lot of money, and failing to get what we need.

There are several other programmatic issues that we suggested in our paper that I will not take committee time for at this particular point. But we would like to make some final and concluding points.

I wish to laud the efforts of the National Federation of Parents and ACTION. I think that they have shown that voluntarism can help. I hope to play a role and our association hopes to play a role in bringing ourselves closer and working more closely with them. They represent a major force in our Nation, and I think offer a great deal of potential. We want to work very closely with them.

I would urge the committee to do anything that you can to support their efforts, as we certainly intend to do.

There is the greatest need for national leadership in this field today than there has ever been. You have heard already from NIDA and from ACTION, and you have had before you various other Federal agencies. I do not criticize any of our Federal programs by themselves.

But I suggest that what we have are pockets of programs, all in their own rights worthwhile programs, doing some good things. But they tend not to be pulled together by anyone. I am not sure who is looking at the comparative success of our supply reduction efforts compared to our demand reduction efforts, or even dealing with that as an issue in a factual way.

We are dealing with some of those issues in pockets of the executive branch, and in different committees and subcommittees of the Congress, but they are fragmented. It is very difficult for people in our communities to keep up with who is doing what, and to get a good picture of what kind of national policy our leadership intends for us to pursue.

I think that this committee has an excellent opportunity to provide leadership, and I know that you have been thinking of those issues. It is a national problem, as you mentioned, Representative Hughes. I believe that it requires a much fuller and much more complete partnership between the Federal Government, and State governments, as well as local governments.

We are particularly faced with a circumstance in which our metropolitan areas; our New York Cities; our San Franciscos; our Detroits; and many other of our large cities really need some special help in this respect. Every time we do statistical surveys, the problem shows itself differently in a national perspective than it does in our cities.

We have special problems in different parts of the country. I am not sure that we have yet discovered how to cope specifically with those special problems. I know that my colleagues in the States wish to do better. Sometimes the political or economic problems of individual States make this difficult.

We could use help from the Federal Government. Please help us exploit the positive signs that we have seen some indications of today. I think that we do have some changes in use patterns. They are not showing up yet in our treatment system but there is hope that ultimately they will.

I hope that we can find some ways to exploit that. I hope that this committee will look, as I know you have from your questions, at what kind of sense it makes on one hand to pull $95 million out of the treatment and service system, and put only $0.5 million into fostering voluntarism.

I agree with the Congressman who was raising questions about that being enough. I think, in many senses, we have been too timid in our determination to deal promptly with the drug abuse problems of our Nation. This is a good time, I think, to renew those efforts.

I can assure you of a high effort among the State leadership. Our State legislatures are deeply concerned. We see the changes. We see our young people killed in highway crashes which we used to feel were just caused by alcohol. We now understand that it is not just alcohol, it is alcohol and a mixture of other drugs, sometimes with alcohol and sometimes not with alcohol.

We have a climate that is ripe for leadership. There is an extremely urgent need for it. We do have money problems, no matter what anybody says. Our treatment system is not able to meet the treatment needs and every time that we fall short, we make the problem worse.

So I stand prepared as a representative of the National Association of State Alcohol and Drug Abuse Directors, and of the Alcohol and Drug Problems Association of North America, to work with you in any possible way that we can.

We are anxious to see the necessary partnership become fuller, to become what it needs to be, so that we can all work together and deal with the problems we must face. Again, I would be happy to answer questions or to submit information later, if you wish to conserve time.

[The joint statement of Mr. Eaton and Mr. Kirkpatrick appears on p. 337.]

Mr. RANGEL. Thank you.

Mr. Hughes.

Mr. HUGHES. Thank you, Mr. Chairman.

And I want to commend Mr. Eaton for an outstanding statement. And I think that you have made a significant contribution today. I particularly laud you for your focusing in on the diversion of licit drugs into the illicit market which has become big business. Even organized crime finds it very lucrative, and they are moving in in the larger cities.

It is frustrating to see professionally that aspect of the Drug Enforcement Administration's budget slashed. We have phased out all of the diversion investigative units that work with the States in trying to develop their expertise. We have many fewer man-hours working on the diversion problem today in the States.

We really do not spend enough time in determining what quantity of various types of drugs actually are being produced in this country. That needs a great deal of attention. So I think that you are right on target in that area.

I was interested to hear you suggest that the law enforcement budget is up so significantly. But unfortunately, that came rather late. The DEA and other budgets were slashed to the bone in 1982, and beyond into the marrow. And it was only because of the efforts of a number of members of this committee, the chairman, Ben Gilman, and many others, that we were able to reverse that trend, but we are still playing catch-up ball.

For example the Bureau of Alcohol, Tobacco, and Firearms is still very much undermanned in spite of the efforts to try to put more money back into that law enforcement program.

In South America, we saw source countries where our efforts are totally underfunded. In Bolivia, there are a couple of DEA agents, when they need about 10. We saw is Peru, with about five DEA agents, that they need about eight. In Colombia, with one agent at any given time in some of the critical field offices, we need at least three DEA agents in each of those field offices.

This inadequate staffing is at a time when we should be trying to contain in those countries the contraband. So I do not want to see us cut back on the law enforcement budget. If anything, what we should be doing is making more of a commitment to bring more resources to the demand reduction side.

I hope that you are not saying that we should divert any of those law enforcement resources over to education and demand reduction.

Mr. EATON. No, I would not suggest that. And I would apologize if it implied that. I was remarking about the imbalance, and the weakness on the demand reduction side. I would not suggest that we are making too much of an effort in law enforcement. I am simply pointing out that I do not think that we are making a sufficient effort by a long shot on the other end of that.

Mr. HUGHES. I think that many members of this committee, after visiting South America, which was a very productive trip, agree that the focus of our international efforts has got to shift to enforcement, working with the law enforcement agencies of those countries to do a better job of intelligence gathering and enforcement.

Fund the crop eradication and substitution programs at a modest level, but make those a secondary goal, not a primary goal, which is the primary goal right now of the Department of State. I saw some crop eradication and substitution programs, as did my colleagues, which I felt were, as my colleague from Michigan would say, were like giving somebody a toothbrush, and telling them to go and clean up the Capitol.

Those efforts are important for a long-term strategy, but I would not want to see us commit any more resources to those pilot programs. They may work somewhere down the pike. But when the farmers can grow and sell coca leaf for five to six times more than they can get for pineapples, they are going to grow coca leaf.

Mr. EATON. I think that is a critical point, and I feel more strongly about it now than I did 5 years ago, because I have seen so much positiveness is the response of the American public to some of the educational efforts that have occurred recently. I see a potentially strong commitment on the part of our schools, our church institutions, and the American public in general.

I did not see this 5 years ago. I saw a great deal of aloofness 5 years ago. And people were kind of saying, well, that is really not a big problem. My brother is OK, or my son or daughter is not really affected.

It is that change which has created an environment which I think offers us so much of an opportunity.

Mr. HUGHES. I agree. I think that the volunteerism and the efforts to try and counter the cultural changes, I think that is how you described it, is right on target as far as I am concerned. But we still need Federal leadership We cannot do more with less. It is as simple as that.

As the chairman has indicated, in New York City, there are 1,400 or 1,500 people awaiting treatment. New Jersey has 10,000 addicts walking around the streets. We have waiting lists of people who we know should be placed in institutions that cannot get help today. And they are hard core addicts in many, many instances who are out committing crimes.

Mr. EATON. Yes; they are.

Mr. HUGHES. 200 to 300 crimes committed per year, an average, whatever it happens to be. It is too high a number, and it has taken too high a toll, and we are not beginning to deal with the problem yet.

Mr. EATON. Right. And eventually those people do wind up in our prisons for sometimes for a second, third, and fourth time. It is far more costly for us to deal with them that way than it would be to provide the adequate amount of treatment services.

We have a good chance in treatment today. We know more about it by far than we knew 5 or 7 years ago. We are not 100-percent successful any more than we are with heart disease or cancer. But we are doing a good job, and we are failing to do that good job with hordes of people.

And something does happen to them. They get on welfare rolls, they commit crimes, they are in our prisons. We are not getting by scot-free just by not providing that treatment. We are simply spending money in other ways, and usually more and larger amounts of money.

Mr. HUGHES. Well, you have made a significant contribution, and I appreciate it.

Thank you, Mr. Chairman.

Mr. RANGEL. Mr. Coughlin.

Mr. COUGHLIN. Thank you, Mr. Chairman.

I just want to commend you on your testimony, and say that at least in my judgment the States play an absolutely vital role in this, because they are the only ones that can mandate drug education in the schools. And that is really the only place that you can get that across, and I think that that is an awfully important role.

Mr. EATON. Thank you.

Mr. RANGEL. Thank you.

Mr. Gilman.

Mr. GILMAN. Thank you, Mr. Chairman.

I certainly want to join in welcoming Mr. Eaton to our committee, and for your concerns, and for the facts that you set forth. It is an eye opener that you estimate the total annual cost of drug abuse will rise to $100 billion.

While we talked about billions of dollars of drug-related crime and the cost of treatment, I do not think that we have had any prior testimony on an estimate of that nature, of $100 billion of a total annual cost of drug abuse. And I appreciate your commenting on how we seem to be moving in the wrong direction with regard to funding for treatment and for reduction of demand at the time that we are confronted with increased imports and increased usage.

Do you agree with Dr. Pollin, who was here earlier, who seemed to indicate that we have less of a problem out on the street than we had back in 1980?

Mr. EATON. Not in that sense. I agree with his observation that we probably have a smaller percentage of people who are using drugs than we did in 1980. In my opinion, we have more people with more severe problems, even though there are not as many total American people who are using drugs.

Mr. GILMAN. Do you have some statistical basis for that?

Mr. EATON. I am afraid that I do not have. What I have is information from our treatment programs where we are not seeing anything but increases in the need for services. We open up new programs, and they fill up immediately.

Unfortunately, I cannot. I have to be impressionistic. And I also have to trust the accuracy of the figures that indicate a reduction in the number of people who are using drugs. If my sons are any indication, I do see some salutory change in attitudes, but I still see a lot of problems.

Mr. GILMAN. You noted that there is a waiting list in many of the drug treatment centers around the Nation.

Do you find that to be prevalent throughout most of the States?

Mr. EATON. Yes, sir, I do. And it is especially true in our inner cities.

Mr. GILMAN. I found almost a year ago in Metropolitan New York in a methadone clinic that there was a waiting list of over 1,000 patients waiting to be treated. And that meant that if they could not be treated, they were out on the street, forced back on the street to satisfy their problems from the illicity drug trade.

Mr. EATON. That is right, and they are very creative about finding ways to do that.

Mr. GILMAN. Is that a typical waiting list around the countryside?

Mr. EATON. It varies; but yes, I think so. I am not sure what 1,000 compares to in terms of total numbers. Our waiting list in Detroit represents something on the order of 10 to 15 percent of our total capacity. In other words, if we were to meet those waiting list needs, we would have to add 10 to 15 percent to our treatment capacity in order to meet it. I do not know how that 1,000 compares.

Mr. GILMAN. How often do your State directors get together to discuss national drug problems?

Mr. EATON. We get together as a membership at least once a year. We are going to try to get together twice a year beginning this year. We have a board of directors which meets four times a year to discuss problems. And we do have working committees.

Although it is difficult for them to meet. They do not have travel funds, and so forth.

Mr. GILMAN. Do you work on national strategy recommendations?

Mr. EATON. We work on national issues. We reviewed that national drug abuse strategy, and made comments to the White House about it. We have not done as much as we think we need to do in terms of developing long-term strategies to recommend to the Congress and to our own membership.

Mr. GILMAN. Have you met with Dr. Turner on a national strategy recommendation?

Mr. EATON. We have commented to him about the national drug abuse strategy that was published. We have not met with him.

Mr. GILMAN. You have not met with him personally?

Mr. EATON. No.

Mr. GILMAN. Have you been invited to meet with him?

Mr. EATON. No.

Mr. GILMAN. Have you been invited to meet with any national policy director with regard to a drug program?

Mr. EATON. Yes, we have been invited often to meet with Dr. Pollin and with the ADAMHA Administrator, but not at the White House level.

Mr. GILMAN. Dr. Pollin with regard to health measures?

Mr. EATON. Well, to drug abuse measures, yes. He is Director of the National Institute on Drug Abuse.

Mr. GILMAN. And have you met with anyone else besides Dr. Pollin on policy matters at the executive level?

Mr. **Eaton.** No, not above that level.

Mr. **Gilman.** When was the last meeting with Dr. Pollin?

Mr. **Eaton.** Fairly recently. He met with our board 2 or 3 months ago, and we have a meeting scheduled with him next month for our full membership.

Mr. **Gilman.** Are you familiar with the national drug strategy?

Mr. **Eaton.** Yes, sir, I am.

Mr. **Gilman.** And how effective do you believe that our Federal drug strategy is at the present time?

Mr. **Eaton.** Well, I have some questions. I think that it will be of limited effect, partly because of the imbalance of effort that is represented on the supply versus demand side. And again, I am concerned about that matter of coordination. I see bits and pieces of efforts, but I do not see a way for them to actually occur. I do not see any structure within the Government to help see that the objectives are carried out.

I am pleased with many aspects of it, too. I like the emphasis on prevention and volunteerism.

Mr. **Gilman.** Have you made any recommendations to improve the coordination?

Mr. **Eaton.** No, we have not. We had considered the so-called drug czar issue. And I have not dealt with that in more detail about functioning, and placement, and so forth, so that we could really determine if that would be a good way to do it or not. We are prepared to do that, sir.

Mr. **Gilman.** In your opinion, are the States bearing a fair share of the problem?

Mr. **Eaton.** I think that the States are bearing a disproportionate share of the problem, especially financially at this particular point in time.

Mr. **Gilman.** Are there any specific programs that your group has recommended that has not been pursued by the Federal Government that you think are of critical importance?

Mr. **Eaton.** Yes, but I do not think that that means that they will not. We have made several recommendations in areas like prescription drug diversion, and many of those are being considered now within the Congress. And we hope that they productively will be considered.

Most of the recommendations that we have made that were not taken had to do with levels of appropriations. In that respect, our recommendations within the executive branch have not been followed. The Congress has been somewhat more responsive.

Mr. **Gilman.** Has the block grant funding program affected your capability to meet some of the problems at the State level?

Mr. **Eaton.** It has drastically reduced them. That is not related to the block grant itself. It is related to the reduction of money that came along with the block grant. As a mechanism, we view it as a good mechanism. And it does provide a flexibility that is helpful.

Unfortunately, many of our programs feel that the block grants themselves brought about the fact that they no longer have as much money, because we had to make reductions in their budgets. So the answer is yes and no. Yes, the reduced amount of money has been a serious problem for us, and we have had to pass that on to the service programs. But the block grants themselves are good mechanisms, and we approve of those.

Mr. GILMAN. If we were to ask you what is your most critical recommendation to us as a committee, and to the Congress, and to the administration on what we could do to be most effective to be of help to our State agencies, what would you recommend?

Mr. EATON. There are two or three programs including ones in the prescription drug abuse area, and three or four others, and we have mentioned those in our testimony, which as a package would help our ability a great deal. I would urge you to look carefully at the level of funding in the block grants, and urge you to consider even a new kind of program that would assist the States as well as volunteer groups to take advantage of the very positive attitudes of the American public now.

That is to move heavily into prevention and into more public education. And I think that the States are in a better position to do that. I think that with leadership here, I am not sure whether it takes money or not, but the States could move rapidly toward seeing that alcohol and drug education are taken up under our school systems.

We cannot do that ourselves, while we do have some unique authorities. So those specialized programs, a review of the block grant funding levels, and a look at some new efforts, national level efforts, that would involve the States, but be instilled by heavy Federal leadership in the public education, information, and prevention areas.

Mr. GILMAN. Thank you.

Thank you, Mr. Chairman.

Mr. RANGEL. Thank you.

On behalf of the full committee, we want to thank you for the great contribution that you made today. In addition to your responsibilities in Michigan, exactly what do you do for the association, how much time do you have to spend with the national association, do you have staff?

Mr. EATON. We do have three full-time staff plus clerical assistance.

Mr. RANGEL. Where are you based?

Mr. EATON. We are based in Hall of the States, just a few hundred yards away from here.

Mr. RANGEL. Where will your December meeting be?

Mr. EATON. It will be here in Washington, D.C., in Rockville, I think, but it will be in this area.

Mr. RANGEL. How many member States do you have with your national association?

Mr. EATON. About 46 of the 50 States. And I expect that most of them will be in attendance at that meeting.

Mr. RANGEL. Do you have any idea as to the exact dates that the meeting is?

Mr. EATON. I do. I think that it is the 6th or 7th of December. We have a staff person here.

[Pause.]

Mr. EATON. December 7 through 9.

Mr. RANGEL. We would like to play some role and get involved with that association. If we cannot do it as members, we would certainly want staff to be involved. We hope that we can ask your association to give us a better idea of some of the problems that you are facing on the State level.

We hope that you will be able to on a State-by-State basis determine or share with us what decisions the States have made within that block grant to see whether or not the drug addict has been able to effectively compete with funds for alcoholism, as you pointed out, or mental health patients.

And I would ask, if I had a chance to be there, and I would ask Jack Cusack to send someone to ask, how do they respond to your statement that these people just do not disappear because there is no treatment available. And the fact that if volunteerism and the State cannot close the gap, somebody is paying for that loose addict being out there being addicted to drugs.

Mr. EATON. Yes.

Mr. RANGEL. We wish that you could share with us on a State basis, so that we can take it to the Federal Government, that loss in productivity, loss in wealth, loss in unemployment, loss in criminal activity, loss in caging someone up in a penal institution are all Federal expenditures one way or the other.

And I think that if we can concentrate on how we can better utilize money without doing violence to law enforcement, without doing violence to voluntarism, that we might be able with your assistance show how we can save the Federal Government some money by not cutting back on these programs in treatment, in prevention, and in education.

So please take back to your membership that we are going to be depending on you as partners in this fight, and we do hope that you would incorporate in our next meeting—you said that you intend to have now two meetings a year?

Mr. EATON. We hope that will be. We will definitely have another one in June in any event.

Mr. RANGEL. Well, you take back to them that I am going to ask the Members of Congress, especially the members of this committee, to see whether we can get involved in your June meeting. And we are going to ask the administration to come, so without the mikes, without the hearing, and without saying which side we are, maybe collectively we can concentrate and focus on those areas where we do have a problem, that is that we have more drugs now than ever before, more abuse than ever before, more loss of lives than ever before.

And without any of us leaving the modality that we feel more comfortable with, we are going to see whether we can do more. So welcome to the team, or open up the doors and let us join with you. You have made a great contribution, as Mr. Hughes has pointed out.

And if you would report back that we will be depending on you to be working with our members in the member States. That is something, too, that we always wanted to do, Bill Hughes, and that is to make certain that their members know that our Members of Congress know where they are.

We would like to be able to use a network. So that when legislation comes up, that we can identify who the membership is we should be talking with, your membership States. Because this is one group that has no constituents, and that is the drug addict. He cannot get a vote, if he needed it.

Mr. **Eaton**. Mr. Chairman, you make me wish that when Mr. Gilman asked me the question about if I had all of my druthers, what would I druther that this committee do, I would like to take my answer back, and ask that you take the chairman's remarks as my answer to that.

We look forward to that kind of relationship, and to the opportunity to deal with these issues in the close fashion that you suggest. You will find our efforts to be diligent, and our concerns to be deep.

Mr. **Rangel**. Thank you for coming to Washington to be with us. And if I cannot get there in December, our staff will be working with your staff, and we will work it out today.

Thank you very much.

Mr. **Eaton**. Thank you.

Mr. **Rangel**. We have a panel here of city representatives. Mr. Paul Robinson, executive secretary of the Coordinating Council on Drug Abuse from Boston, and the immediate past chairman of the National Association for City Drug and Alcohol Coordination.

With him will be Dr. Nicholas Piccone, executive director from Philadelphia of the Coordinating Office for Drug and Alcohol Abuse Programs.

And, of course, from the District of Columbia, Dr. Alyce C. Gullattee. She made an outstanding contribution to the congressional Black Caucus weekend, and we have not forgotten her contribution to the Nation as well as to the District. And she is the director of the Institute of Substance Abuse and Addiction, Howard University, Washington, D.C., and former administrator of the Alcohol and Drug Abuse Administration, Washington, D.C.

All of you are experts, and we do not have any problem that you know more about this subject than we do. But we do believe that it is necessary that we share in that expertise, and try to follow your guidance on how we can be doing a better job here in the Congress.

For that reason, what I am going to do is to ask the committee's permission to put your full statements in the record, and suggest to you that if you could highlight that testimony, and give us direction without repeating those things that we heard this morning, then we could best utilize the time that we have given to us for this purpose.

Is there any objection to receiving the testimony for the record?

[No response.]

Mr. **Rangel**. Without objection, it will be received. Mr. Robinson, you may proceed.

TESTIMONY OF PAUL E. ROBINSON, EXECUTIVE SECRETARY, COORDINATING COUNCIL ON DRUG ABUSE, CITY OF BOSTON, IMMEDIATE PAST CHAIRPERSON, NATIONAL ASSOCIATION FOR CITY DRUG AND ALCOHOL COORDINATION

Mr. **Robinson**. Mr. Chairman and members of the Select Committee on Narcotic Abuse and Control, I am Paul Robinson, and I appear before you today as the executive secretary of the city of Boston's Coordinating Council on Drug Abuse, and as the immediate past chairman of the National Association for City Drug and Alcohol Coordination.

I appreciate your invitation to join you today to provide an urban perspective on the 1982 Federal strategy on the prevention of drug abuse. I provided the select committee with a review of concerns regarding the effectiveness of the strategy as it pertains to the city of Boston, and to the Nation's major cities in general.

I am grateful for the opportunity to briefly elaborate on my written testimony with a statement that I hope will illustrate the salient issues which most concern my colleagues whose responsibility is to translate the 1982 document into actual services for the residents of our cities.

My initial reaction to the strategy was concern over the lack of attention to what earlier administrations and Congresses had concurred was a major national problem, the veritable epidemic of narcotic addiction in our large urban areas.

The strategy in its sole reference to this matter acknowledges that the drug problem of a large city may be quite different from those of a small town. I would digress for a moment, and recall a statement made to me by the President's adviser on drug abuse in Boston when he and Michael Landon and others were up doing the pharmaceutical picture on drug abuse, when he asked how is the drug problem, and I said here in Boston, it is very severe, we have an estimated 10,000 to 12,000 heroin addicts.

He said, no, how is the drug problem out in the suburbs, we are not interested in the drug problem in the cities.

After this somewhat less than incisive analysis, the document proceeds to spend 11 pages discussing international cooperation. This choice of emphasis is startling in light of reports from New York City, Detroit, Philadelphia, Los Angeles, Boston, and other principal population centers which very clearly indicate as you know, Mr. Chairman——

Mr. RANGEL. Excuse us, we are not following your testimony.

Who did you say made that remark?

Mr. ROBINSON. Dr. Turner.

Mr. RANGEL. I am terribly sorry.

Mr. ROBINSON. Actually in the testimony, it is more near the end.

With respect to the strategy, I believe that it is flawed in three fundamental ways. First, it was apparently prepared in a hot house environment with no apparent effort made to reach out to the principal sites of serious addiction.

Certainly, local government addiction service coordinators were not systematically involved, and their experience and perspective were evidentally neither consulted nor desired, a peculiar situation for the preparation of a Federal strategy, for what we are told is a major campaign against drug abuse.

A logical result of this limited, narrow base of input to address what is represented as "one of the gravest problems facing us internally in the United States" is a limited, narrow perception of the issue itself.

Only 20 pages of the 75-page document are directly related to demand reduction. No concern is expressed for the burden which large cities uniquely face in addressing these matters.

Therefore, it follows that first, with inadequate input and research, and second with the glaring inaccuracy or misperception of the problem, as it is manifested in cities in every region of the country, that the mayors of our large cities are not provided with any genuine strategy in playing a role in planning, coordinating, or providing prevention and treatment services for their cities.

In effect, Mr. Chairman, the 1982 strategy seems a classic case of garbage in, garbage out, and it is in no sense either Federal or intergovernmental, nor is it a strategy.

When I first read this document, I felt that it portrayed a basic disinclination on the part of the administration to engage in this issue in a meaningful way. However, even if I had been willing to adopt the advice of a previous administration, "watch what we do, not what we say," the development, implementation, and funding of the alcohol, drug abuse, and mental health services block grant would have persuaded me that this administration is interested in promoting the addiction issue only for public relations benefit.

In short, the real contribution of this administration in managing addiction problems for our cities rests on the effectiveness of a strategy which ignores them, and upon a funding mechanism which will, probably in the next fiscal year contribute to the destruction of a fragile substance abuse service system which has taken a decade to develop, and now has been slashed to ribbons by Federal funding cuts.

In effect, Mr. Chairman, we have watched the administration abdicate its Federal leadership role in meeting the challenge of urban narcotic addiction. And I submit that this hearing may be the last opportunity for major city addiction services coordinators like myself to present testimony to a congressional committee, and ask for the preservation of our programs.

The committees of the 99th Congress may well be convening hearings to determine how to rebuild the cities' treatment and prevention systems, which finally collapsed under the double effects of increased demand and diminished Federal support.

In my written text, I discussed the ramifications of the failures of the alcohol, drug abuse, and mental health services block grant in detail, and I am critical of the roles of both Federal and State authorities in permitting this funding structure to weaken the participation of local Governments in addiction services planning and coordination.

However, I wish to make it clear that my colleagues at the State level have been articulate and energetic in addressing the Federal abandonment of drug abuse services.

It is my hope that by our joint presentations to this select committee today, that we can prove not only to be eloquent, but ultimately persuasive. The select committee has the quantitative data on hand to document the extent to which Federal support in this field has diminished at a time when waiting lines for urban drug abuse services are lengthening.

We all realize that treatment delay is not only treatment denied, but that the social costs, including public safety as well as health care, rise dramatically as the time lag in providing treatment increases.

In effect, even in an administration motivated by that sort of financial data, not to mention human potential, would be prepared to investigate, acknowledge, and address the issue of urban addiction. Perhaps this is a situation which addiction service coordinators and providers need to present in greater detail.

However, in a period when cities have been left to fight a major conflagration without adequate fire extinguishing equipment, we find ourselves with understandably diminished resources for preparing exhaustive analyses for Adminstration officials.

Indeed, these officials need only to step into our streets to witness the effects of their decisions to disengage from drug abuse prevention effort, and thereby reducing the city's response.

Mr. Chairman, I am pleased to have been able to address these issues before this select committee as a member of panel of distinguished colleagues. On behalf of its chairman, Dr. Nicholas Piccone, I offer the services of the National Association for City Drug and Alcohol Coordination to assist the select committee in its continuing review of urban addiction issues.

I would be pleased to respond to any further questions that you may have today.

[The prepared statement of Mr. Robinson appears on p. 363.]

Mr. RANGEL. Thank you, Mr. Robinson.

I am certain that the administration will want to have an opportunity to respond to this committee to the statement attributed to Dr. Carlton Turner. On page 9 of your written statement, that is submitted. And Mr. Leonard is still with us. So let the record indicate that we would like a response to the statement attributed to Dr. Turner, which I am sure that he took notes on.

Let me ask you before we go on to our next witness.

Mr. Robinson, are still a member of the National Association for City Drug and Alcohol Coordination?

Mr. ROBINSON. Yes, sir.

Mr. RANGEL. And who is the president or chairman of that?

Mr. ROBINSON. Dr. Piccone.

Mr. RANGEL. Very good.

Do you know who would be participating from the city of New York with your association?

Dr. PICCONE. At the present time, New York City does not have one.

Mr. RANGEL. We do not have a drug program. So what you were talking about may happen has already happened to us. Dr. Piccone, would you proceed.

TESTIMONY OF DR. NICHOLAS L. PICCONE, EXECUTIVE DIRECTOR, COORDINATING OFFICE FOR DRUG AND ALCOHOL ABUSE PROGRAMS, PHILADELPHIA

Dr. PICCONE. Mr. Chairman, members of the select committee, I am Nicholas Piccone, executive director of the Philadelphia coordinating office for drug and alcohol abuse programs. It is a component of the Philadelphia Department of Public Health.

The coordinating office for drug and alcohol abuse programs known as CODAAP was created in 1973 to develop and administer a drug and alcohol prevention and treatment system in Philadelphia County.

During the past year, the new Federalism has cut deeply into our ability not only to provide high quality services to all those in need, but to continue to focus on those management principals needed to run an effective system.

It has been a year of responding to fiscal crises. It has resulted in severe curtailment of prevention programs including summer alternative programs for youth at risk, as well as elimination of all ancillary services such as vocational and educational training. It has also culminated in the closing of program, and has contributed to large scale over utilization of remaining programs.

Of course, this has a negative impact on client care. In fiscal year 1981, the city of Philadelphia received a total of over $7 million from the Federal Government. In fiscal year 1985, we are slated to receive $4.5 million.

Considering inflation and cost-of-living increases of the 4-year period, the impact of this loss on our system is in a word devastating. That is a cut of almost 40 percent.

The city and county of Philadelphia with a 1980 population of 1.7 million is the largest city in Pennsylvania and the fourth largest city in the United States. Philadelphia as a major metropolitan area is beset with a myriad of problems not always identified with other less populated areas.

A variety of social and demographic indicators such as unemployment, deaths, crime rates, as well as treatment service indicators depict the drug abuse problem in Philadelphia. Unemployment is extremely high among clients in Philadelphia.

Approximately 75 percent of the clients in Philadelphia treatment programs are currently unemployed. According to recent data from the drug abuse warning network, DAWN, heroin related deaths and all drug related deaths in Philadelphia have increased, narcotic arrests and offenses have increased continuing a trend which started in the first 6 months of 1980.

Intakes for users of heroin and barbiturates have increased. Cocaine used had increased by 30 percent since 1981. In fiscal year 1982, that is the most recent year that we have data available for, there were approximately 19,000 admissions into CODAAP or Philadelphia funded substance abuse programs.

Of these admissions, 47 percent were admitted for drug abuse problems. During this year, 5,000 clients were admitted for heroin and other opiate abuse. In any given time during the past several years, there have been at least 2,300 clients receiving services at 11 methadone maintenance programs.

This currently represents 130 percent utilization of 1,834 funded slots. Among drug abuse admissions in Philadelphia, the second highest category of primary drug abuse after heroin and other opiates is amphetamines, of which there were 1,500 in fiscal year 1982.

DAWN data for calendar year 1982 places Philadelphia as the fourth highest in the country exceeded only by New York, Los Angeles, and Detroit in emergency room and medical examiner episodes involving drug abuse. The most frequent episodes in hospital emergency rooms in the Philadelphia metropolitan area were alcohol in combination with drugs—valium, heroin, amphetamines, in that order.

Of special significance is the fact that in 1982, there were 57 percent more heroin emergency room mentions than in 1981. The extent of the drug problem in Philadelphia can further be seen via the current utilization rates of Philadelphia treatment programs.

Of the 42 CODAAP contract facilities providing drug abuse treatment services, 62 percent are above contract capacity. That is greater than 100 percent utilization. And 81 percent are above 90 percent utilization.

When we look at a system stretched to its limits and beyond, we become concerned about continuing to provide quality care. We developed allocations and contracts with drug and alcohol agencies that establish standards for both quantitative service objectives and quality care.

When demands for service increase beyond the agency's reasonable capabilities, our expectations have to be lower. With increasing overloads, stress on staff increases, staff morale is lower, and staff burnout occurs more frequently.

I would like to specifically comment on the impact that present block grant funding levels and mechanism have had on Philadelphia's drug and alcohol services system. As I have indicated earlier, we have worked to maintain a comprehensive array of drug and alcohol abuse services in a period of increasing fiscal stress and erosion of funding.

Philadelphia agencies funded through CODAAP have received no significant funding increase since 1979. CODAAP had developed and implemented funding criteria designed to maximize productivity while maintaining quality of services delivered.

We have intensified our program monitoring to increase accountability in this system. However, we have reached a practical limit in these efforts. And the additional 25 percent loss of Federal block treatment funds now scheduled for fiscal year 1985 by our State agency may cause catastrophic reductions in services.

The New Federalism as designed and implemented by the present Administration in Washington gives the State full responsibility for the allocation of Federal block funds. This movement away from direct Federal funding is wreaking fiscal havoc on Philadelphia's drug and alcohol abuse service system.

Let us focus on the actual loss of the city's drug and alcohol abuse service delivery system due to the erosion of Federal and State support. A review of the block grant cutback schedule both as planned and actually implemented by the State office of drug and alcohol programs reveal how difficult it has been and still is for CODAAP to provide rational proactive planning for the system.

Philadelphia was instructed by the State to plan for a sequential cut of 15 percent, zero percent, and 10 percent over the 3-year period, fiscal year 1983 through fiscal year 1985, for a total cut of approximately $1.5 million.

In actuality, true cuts of 15 percent, 4.5 percent for fiscal year 1983 and fiscal year 1984, and a 25-percent cut is now projected for fiscal year 1985 amounted to a total reduction of $2.7 million.

This will represent a loss of 40 percent of Federal funds over this 3-year period. Other revenue that is generated by the provision of these services as added to the Federal block schedule, the true dollar loss in services approaches $2 million for fiscal year 1985 alone, and approximately $4 million over the entire 3-year period of fiscal year 1983 through fiscal year 1985.

An example of this revenue loss in fiscal year 1985 in human times may mean the elimination of two major comprehensive alcohol and drug abuse treatment programs in their entirety. This cutback represents the elimination of about 79,000 service units delivered through outpatient, residential detox, methadone maintenance, emergency care, and polydrug treatment for about 6,000 client admissions.

At the agency staff level, this also represents a loss of about 160 staff positions. These are field positions. This loss will be added to the nine drug and alcohol agencies or service components that have either been defunded or closed as a result of the system's dwindling fiscal resources since fiscal year 1982.

Philadelphia is suffering this reduction in services at the same time that economic factors in our society demand even more services for severely stressed urban populations.

Let me now comment on the way that the State of Pennsylvania has managed block grant funding to the detriment of the city of Philadelphia. Severe fiscal reductions noted above result from the new formula or method of allocation being implemented by the State department of health office on drug and alcohol programs.

This formula is based on a statewide distribution of funds which will realize per capita and equity increases to all counties but Philadelphia. The basic rationale seems to be something than the actual drug and alcohol service needs of any given county.

If you review the uniform data collection system reports from January to April of 1983, you get a clear picture of our city's drug and alcohol service needs. In these reports, it is reflected that 75 percent of our programs for clients are overutilized, some by as much as 200 percent. The remaining 25 percent are utilized between 85 and 100 percent.

These statistics emphasize the overwhelming need for drug and alcohol services in Philadelphia. This need is not being considered as an important funding variable by the State.

Federal block grant legislation requires that at least 20 percent of the State drug and alcohol block grant dollar allocation be assigned to funding prevention services. Unfortunately, since no additional funds were appropriated for prevention services, this 20 percent has been taken away from existing already overutilized treatment services in Philadelphia.

In Pennsylvania, the State strategy further penalizes Philadelphia. After taking the prevention set-aside funds from Philadelphia treatment service funding, the State office did not choose to take the logical step of applying the Federal block prevention funds for Philadelphia whose documented need has long been established.

As I noted above, the State chose to distribute the prevention block funds throughout the State excluding Philadelphia using so-called per capita and equity formulas. Because this money is not allocated on a need basis, the State is in a position of having a $1.5 million surplus of prevention block funds in fiscal year 1985 for which they appear to have no plans.

At the same time across the State, there will be a $2.8 million shortfall in treatment block funds. We would like to strongly recommend that States be required to allocate Federal block funds on the basis of need with monitoring by the Federal Government to insure that this requirement is in fact being met.

As a result of the State's actions, Philadelphia treatment programs in fiscal year 1985 will have lost 40 percent of the Federal funding that they were receiving before block grants were implemented. And in spite of the congressional mandate emphasizing increased funding for prevention, in fiscal year 1985 there will be fewer Federal dollars for prevention in Philadelphia than there were in fiscal year 1981.

We endorse the position that more funds should be made available for expansion of prevention services. But such funds for prevention should not be taken from existing overutilized treatment services.

I would like to present our specific recommendations at this time.

Mr. RANGEL. We have those specific recommendations, and they will be included in the record. And we want to make certain that we hear from the entire panel, because I think that it is important that the members have an opportunity to raise some questions.

But we want to thank you for a very detailed statement.

[The prepared statement of Dr. Piccone appears on p. 380.]

Mr. RANGEL. Doctor, thank you for your patience. Dr. Gullattee, welcome back to our committee.

Dr. GULLATTEE. Thank you, sir.

TESTIMONY OF DR. ALYCE C. GULLATTEE, DIRECTOR/ADMINISTRATOR, INSTITUTE OF SUBSTANCE ABUSE AND ADDICTIONS, HOWARD UNIVERSITY HOSPITAL, WASHINGTON, D.C.; FORMER ADMINISTRATOR, ALCOHOL AND DRUG ABUSE SERVICES ADMINISTRATION, WASHINGTON, D.C.

Dr. GULLATTEE. Mr. Chairman, and members of this Select Committee on Narcotics Abuse and Control, my name is Alyce Gullattee. I am an associate professor of psychiatry and family practice at Howard University Hospital, and the director of the Institute of Substance Abuse and Addictions for Howard University.

I have recently spent 22 months on IPA assignment loan to the District government as head of the Alcohol and Drug Abuse Services Administration.

I am thankful for this opportunity to reinforce the much overworked reality of the seriousness of substance abuse in our Nation. With the number of experimenters, users, abusers, chippers, addicts, and burnouts increasing dramatically, our need for vigilance and tenacity in tackling the problems of substance abuse is profound.

The multiplicity of theories about the etiology of substance abuse only focuses on the fact that we do not know why it occurs among those who are affected. The historical notion that the underprivileged, impoverished, immoral, black, antisocial, psychopathic person fits the description of the dope fiend can no longer be adhered to.

It is as if we have multiple generations who express their displeasure and their frustration with our American way of life by symbolically removing themselves from reality through mind altering substances. This method, deviant though it may be, is for some the only way that they can articulate, if you will, their pain with self and others.

I do not wish to romanticize the harshness of this alien posture and the agony that it has caused and continues to cause all segments of the population on which it impacts, but rather to emphasize the need for you as legislators and for those of us as health service deliverers to be realistic about what the treatment needs are and what the outcomes must be or may be.

In our national pathos, we have perhaps inadvertently perpetuated the problem. Without ethnocentric stereotypy, we have deprived those who have needed our help from receiving it through avoidance, denial, and displacement.

With intellectualization, we have reasoned out the negative effects of the gateway drugs, cigarettes and beer, and thus rendered our young impotent to make a decision about the harm over time of such drugs. More and more, we see the young modeling one generation after the other, and alienating themselves from parental groups.

Even those who resolve in a positive way their perplexity about the adult world tend to want isolation for a period of time in order to regroup. Perhaps it has been our Nation's expansiveness and attempt to be all things to all people, a simulated creator, if you will, that has hurled us into a century of preoccupation with drugs and their effects.

We do not, however, move back to natural substances, but rather toward better ways to alter the self. Poor self image is endemic, and the epidemic to alter that image is substance abuse. The problem is compounded if you cannot read, write, or work.

I have outlined in my testimony what the newest revenue sharing method, the Omnibus Reconciliation Act, has done to decrease drug and alcohol treatment potential, by giving essentially carte blanc utilization of limited funds to states. There are several methods to hold or hold hostage the funds extending from multiple budgets, requested, appropriated, congressional, departmental, and final program superimposed upon which is a spending plan of directive distribution and reprograming for other purposes, and finally attenuation of new initiatives even in the face of successful programs.

The need for safeguards are apparent. The District of Columbia is a prototype of the Nation, because of its unique city/State configuration. And statistics about the drug abuse problem have been included for your perusal.

Our need for greater consolidation of public effort and linkage development with the Federal agencies to combat our problems are evident. However, with the exception of special law enforcement task forces, we tend to remain territorial.

This is the written statement that I have prepared, but there are some other comments, however, that I would like to make. The omnibus bill gave reference to the possibility of technical assistance on the part of the Secretary's Office for programs and for States.

It would appear, however, that technical assistance has not come forward from the Department of Health and Human Services, and particularly in a State such as this here, the District of Columbia, from some of those persons who have nothing to do with their time other to theorize in their offices out at Parklawn. Their services could be utilized by us in the cities, since we do not have adequate funds to hire persons to do specific jobs that we need done in the cities.

We also find that there is a problem associated with overlapping jurisdictions. And I am certain that this is not just peculiar to the District of Columbia. We find that there are funds in social funds in social service for direction for substance abuse, both alcohol and drugs. We find that in block grants for public services, there is money that can be utilized for alcohol and drug abuse efforts.

We likewise find that there are funds in law enforcement that are targeted for substance abuse treatment, prevention, and education, but rarely do treatment people who are responsible for the overall management of and/or determination of need and distribution have any contact in the process of deciding how those funds are to be used.

I give as an example a disservice that the omnibus bill has done to us, or perhaps it has been the decision on the part of managers at the ADAMHA level or at DHS. They have cut us off from a clearinghouse which is clearly one of the most needed organs that we should have available to the public.

I know this to be true, because sitting as the head of the ADAS Administration in the District of Columbia, I received thousands of letters from youngsters throughout the whole United States, who because of their lack of knowledge of what was going on in the District believed that the ADAS Administration represented an extension of the Federal Government.

And therefore, they would write for clearinghouse kind of materials, oftentimes giving small vignettes about why they were asking. Because they had a course in their school that they did not fully understand what was going on, they wanted more information. And this was from the third grade all the way up through the 12th grade.

So the clearinghouse mechanism could clearly have provided the States with adequate information and material for distribution, but even more it could serve as a vehicle for illumination and elucidation of problems associated with substance abuse from a realistic and factual point of view rather than something that might be anecdotal, or something that might be emotionally based, or something that might be speculative.

Because it is the responsibility of the Federal Government with its vast moneys to provide accurate information which then can be distributed to those persons in need.

I have learned a great deal about self-help groups and volunteerism. Volunteerism appears to be fine perhaps if generated in the private sector. But because of rules of confidentiality that bind those of us who treat drug and alcohol abusers, it is rarely a mechanism whereby impacts can be made upon manpower needs in programs.

Sometimes the persons who wish to volunteer are no more than social voyeurs, or who many in some instances have some grandiose thought in mind of what they might do if they were just to speak to the persons who were drug abusers, only to find themselves that if they were to come in contact with the hardcore people whose lives revolve around drugs to be somewhat shaken by the reality that this is not going to alter the nature of the ever increasing drug abuse problem that we have in the country.

I think that self-help groups, such as Narcotics Anonymous and Alcoholics Anonymous, have not been given as much credit for the services that they do to the population that we serve.

In black communities, Narcotics Anonymous has never really been a force to be reckoned with. But in recent years, there has been more and more emphasis placed upon that particular modality as an extension of a treatment facility, because it represents a group of persons with similar experiences who can by nature of their testimony to each other be it on a Christian basis or not share some of the problems extant for those persons who live every single day in that drug foraging behavior.

They have not been given the kind of status that volunteerism appears to have been given. Perhaps it is my naivete in stating this, but I certainly feel this. I see even in our city the impact that Narcotics Anonymous and the Narcotics Anonymous group for adolescents have had in impacting on not only the person who is the drug abuser, but also upon the families of such drug abusers.

It would appear as if the parent group phenomenon is likewise something that we overstate rather than really take a very serious look at the impact that they have upon what is happening throughout the country. Now there are pockets of parents groups that are very active. But in other areas, particularly in the urban centers, except for a few church groups that might decide that they are going to pull together in order to help overcome the program, parent organization and activity is not the same as it is touted as being throughout the rest of the country.

I was disturbed when I heard the gentleman indicate that a group of volunteers had gone into Alabama to organize poor—and I do not want to misquote him—but I do believe that his reference had to do with poor persons, and he might have even said something about the ethnicity. But it struck me as being peculiar, that someone from outside would have to come into Alabama in order to help organize the parents around an issue about which they knew a great deal, and probably had great frustration in not knowing about how to resolve it.

It would seem better that that money would be better placed if it were in the State of Alabama, and were in some way filtered out to that community in order for those forces in the community to make a decision about how best they need to organize.

I think that there is a great wealth of energy among indigenous individuals in the community, particularly as they relate to the problems of substance abuse, and we do not give enough service in that area.

I have the feeling that we need more throughout the country in terms of diversion investigating units. I was interested in hearing what Dr. Piccone had to say, because for the longest period of time, we in Washington, D.C., had to bear the burden of the amphetamine distribution from Philadelphia, being its primary dumping site in the District of Columbia. And the question came up as to whether or not the two mayors could talk to each other about how best they could impact on the prescribing behaviors and/or the look-alike drug manufacturer's behaviors in that particular State, because we were having to pay the price for that here in Washington, D.C.

Diversion investigating units were first set up, as you know, by LEAA, and they have proven to be a worthy contributor to problems associated with diversion of drugs from the licit market into the illicit market, controlling behaviors of physicians who tend to write and sell scrips, behaviors of pharmacists who tend to fill scrips without questioning the quantity and/or the true signature on those scrips.

It has served to question as well the behavior of dentists, the behaviors of all of those groups that have access to drug enforcement numbers, and the right to prescribe controlled substances.

Also, there is an opportunity to share information about trends, about what is happening within your community, because the diversion investigating unit is generally composed of a representative from the U.S. attorney's office here in the District of Columbia, the Board of Pharmacy, the Board of Medicine, representatives from the Laws Division, representatives from the local medical societies, representatives from the universities, and a public representative if that public representative had any oversight responsibility for any of the funding of that unit.

It serves as a mechanism for interagency interaction, so that the community will not feel that they essentially are without protection from the different groups that might be responsible for the movement of drugs out into the community.

Diversion investigating units should be absolutely part of whatever a block grant in a State should fund, if they have not yet funded them.

I mentioned in my testimony something that concerned me greatly, and I do not know whether it is because the District is backward or not, and it is not a popular statement to make, but I make it anyway. For the District of Columbia to have 40,000 patient records since the beginning of the Narcotics Treatment Agency, none of which are on computer, so that to recall the information instantaneously would be a tedious job that would have to be done by hand, seems almost incomprehensible.

Why automation has not come into place, I suspect, has something to do with the attitude that not only the city has, not our Mayor, but the city has had over time, and perhaps over the United States have had over time about substance abusers who are looked upon as being end products of their volitional behavior that has gone out of control.

Perhaps that might have been what could have been justified in past years for essentially denying, avoiding, and benignly neglecting that group, but because of the ever increasing numbers of addicts that there are, and because of the people who are impacted by the problems of addiction, it would behoove us to have some crosstalk on those records.

Because more and more addicts are shopping around for the best environment in order for their needs to be met. And they will be in a program here, and commute to a program in New York, and commute to a program in Philadelphia in order to have what their daily needs might be.

In our clinics alone, we find that only 25 percent of our people work—48 percent of them do not work, and are not receiving public assistance. If drug foraging is a 24 hour a day job 7 days a week, then those people are working on us by their behavior in terms of making the necessary moneys to purchase whatever it is that they need.

We need to do something about having a national system that will help us identify the people no matter where they are who are involved in drugs.

I looked at the drug strategy, and in my testimony I say, "I have great concerns as I have articulated before about the substitution of one drug for another." Our system got into the problem that it is in now with attempting to substitute for opium, and we have ended up now with a heroin problem.

We do not know the long-term consequences of LAAM, or Naltrexone, or Clonidine, or some of the other drugs that might allow a person not to come to treatment as frequently as the present system requires.

But I implore you to recognize that day to day contact for people who have nothing to do with their time other than to prey upon others represents a therapeutic moment for those clients. If for no reason other than they must go someplace and adhere to some structure in their lives, it is necessary that they come on a day to day basis, even if a LAAM, or a Naltrexone, or a Clonidine were substituted for it.

But generally, it is touted as a mechanism for cost reduction, and therefore the need for fewer persons in order to provide the services.

I cannot overemphasize to you the need on the part of the legislature to see to it that more moneys are made available for education, prevention, and early intervention. I have the philosophy that the dilemma that we face is not so much the need for moneys, as seen as the present strategy to provide treatment, but the need is to provide funds for detention.

Because more money is going into building of cells now to detain people throughout the country than is available for treatment throughout the country. But I do not see detention as a negative force in some instances. That perhaps is the only time when some individuals are allowed to adequately reflect upon themselves and upon their behavior.

So for those persons who may spend five or six times going back and forth into programs, detention may be an end point of rest for them, the same way as it used to be for the old alcoholic who was on the street with no place to go in the winter. And suddenly his alcoholism became a disease, and he forages out in the street because he does not have anyplace to go.

But we need more moneys for education, prevention, and intervention. The Department of Education needs to talk to NIDA. We need to have more demand that there be a consolidation of Federal effort in order for us to overcome our very serious problem.

I think that I have articulated most of the problems that are in my head. I do believe that no program is ever going to work in this country to relieve the problems of substance abuse unless it has as a component part of it a vocational rehabilitational aspect. People who cannot do anything will find something to do with the nothingness in their lives.

I share with you this. A lady walked into the hospital yesterday with her baby in her arms. It had been born with the cord wrapped around its neck. She had just shot up several hours before the baby was born. She had six other children.

She said that she had no warning that the baby was coming. A drug addicted mother who brought in her arms her drug addicted baby, and delivered the placenta after she walked in with the baby.

I share with you the recent birth of a child with severe, severe phenoalcohol abnormalities, far outside those that are normally defined for persons who drink alcohol over time. I share the problem of the child born without a limb because it did not get the signal to properly grow, and the only thing that the mother was addicted to at 17 was marihuana.

Why is it that this kind of factual information is not available in the school system for young people to make decisions about their lives? At the end of the spectrum when they become involved, they can always say I did not know. This is not information which we have not known for a long period of time. Why is it that it is taking so long to filter down into the textbooks in a reasonable way, so that it can be understood in terms of decisionmaking, and in terms of impact upon the physiology and the biochemistry of the developing body of the young males and the females.

We see an ever increasing number of women who are addicted, heads of households who are going to come into contact with children. We know very little about the female addicted population, and why is that.

Best that some of the time that is spent on trying to theorize on how they can give out contracts to do more and more data collection on the part of NIDA and NIAAA, they should become involved in a more meaningful way with the States by loaning out their individuals who have the expertise epidemiologically and demographically to help ferret out some of this kind of information.

If the government is not going to give us more money and the private sector and foundations are not going to necessarily give us more money, then we have to find ways to come up with the needed information, so that we can provide the next generation with enough adequate information, so that 20 years from now they would not have to sit in this position at the turn of the century and talk about the same sort of things that we were talking about at the turn of the century in 1864 and 1898. We were talking about smoking opium, and this sort of thing. We are right back full circle once again.

Mr. **Rangel**. Thank you, doctor.

I have to make a telephone call. Would you see that the members inquire, and I will be right back.

Mr. GILMAN. I want to thank the panel for their presentation to us, and for stimulating our thinking about the problem out there, and for the excellent presentations. I will withhold my questioning.

Mr. Hughes.

Mr. HUGHES. Thank you very much, Mr. Chairman.

First, let me just commend the panel.

Dr. Gullattee, I have never heard a finer statement really. You were eloquent, and there is not a thing that I would disagree with. I just have a couple of questions.

What is the present waiting list in your respective communities, those addicts that need help that we cannot reach, how long is it taking us to get to them? Mr. Robinson.

Mr. ROBINSON. In Boston, it is ranging from 3 weeks to 6 months.

Mr. HUGHES. Philadelphia?

Dr. PICCONE. It ranges from 2 to 3 months.

Mr. HUGHES. D.C.?

Dr. GULLATTEE. More than 3 weeks.

Mr. HUGHES. More than 3 weeks, OK.

On the diversion investigative units, Dr. Gullattee, as you perhaps may know, those units have been zero funded, and there is no money in the budget for those units, I regret to say. And I share your concern, because I think that they have had a very positive impact.

The Drug Enforcement Administration has done an outstanding job in providing leadership to communities in ferreting out the diversion of licit drugs into the illicit market. And that is a major source of substance abuse, as you well know, in our communities around the country.

I had hoped that in the conference on the State justice appropriation, that we could have preserved some of the money. And I know that a number of members of this committee have worked on it trying to get funding in there for that, but it is not funded.

I also regret to report that we are down substantially in the personnel who would investigate the diversion of licit drugs. The investigative capacity of the DEA has been unfortunately significantly undercut, because of a major cut in that area of the DEA budget.

Dr. GULLATTEE. Mr. Hughes, may I ask a question?

Mr. HUGHES. Sure.

Dr. GULLATTEE. Is that because of the pharmaceutical industry lobbying?

Mr. HUGHES. No, that is just because of major cuts that came about in 1981. And at that time, our efforts to try to save DIU and avoid the cutbacks in investigative work years in that area of the budget were not totally successful. So we are still suffering some of those cuts.

Well, again, thank you very much for your testimony. I share your concerns, and there is not a thing that I heard from this panel that I do not wholeheartedly agree with. You were most eloquent. Thank you very much.

Thank you, Mr. Chairman.

Mr. GILMAN. Thank you, Mr. Hughes.

I would like to ask the panel this, first of all. We heard from Dr. Turner and Dr. Pollin that apparently the incidence of drug abuse has been declining in the last year or two. You are in critical areas, each of you.

Are you finding that to be a valid statement, or do you find that the incidence is increasing, status quo, or decreasing? I would like each of the panelists to comment on that.

Dr. **Gullattee**. Perhaps that it would be best to indicate that there appears to be a slight decrease in the use of heroin, a sharp increase in cocaine, a sharp increase in PCP, what is called lovely, et cetera.

Mr. **Gilman**. And in the number of abusers in those areas?

Dr. **Gullattee**. I am sorry.

Mr. **Gilman**. You say an increase, also in the number of those who are using?

Dr. **Gullattee**. Yes. And an increase in combination drugs, heroin and amphetamines.

Mr. **Gilman**. Have you seen this develop in the last year, or 2 years?

Dr. **Gullattee**. In the District of Columbia, there has been an increase over the past 3 years. This is for the first quarter of 1983. We are seeing a slight decrease in pure heroin use, but an increase and/or steady state in all of the others. An increase in cocaine, an increase in PCP, an increase in combination heroin. And, of course, in the District, an increase in heroin and alcohol.

Mr. **Gilman**. And what do you base your assumptions on, statistical information, where do you get your information, what is your data base?

Dr. **Gullattee**. We get our information from our treatment clinics, from our intake unit, from DAWN data in terms of emergency room data, our overdose death rates which are reported.

Mr. **Gilman**. Who assembles that data and analyzes it for you?

Dr. **Gullattee**. It is assembled by the executive branch of the intake of the central intake division, All persons coming into drug abuse programs in the District of Columbia go through one central point.

Mr. **Gilman**. And do you get a regular report on that information?

Dr. **Gullattee**. Yes.

Mr. **Gilman**. How frequently?

Dr. **Gullattee**. Each month, I get a printout of all overdose deaths, where they occurred, the drugs that were used, at least when I was there at the center. I would get weekly reports. I would get a daily census report from all of the units in the District where drug abusers were going for treatment, a weekly compilation, and a monthly report. And that would be sent forward to the Office of Health Planning in the Department of Human Services.

Mr. **Gilman**. And are your findings similar to the findings that NIDA has reported with regard to the incidence of use in the metropolitan areas?

Dr. **Gullattee**. We have some differences with NIDA, because they use standard metropolitan statistical areas. But we do report to NIDA. Although now under the block grant, we are not required to report any of the data that previously we had to report. We continue to collect CODAAP data.

Mr. Gilman. When was the last time that you reported to NIDA, that you were required to report?

Dr. Gullattee. Well, in 1981. But we reported to NIDA in 1982. We continue to share our data with them, although we are not by law obligated to do so.

Mr. Gilman. Does your information differ from NIDA's report to us on the decrease in street use?

Dr. Gullattee. Yes.

Mr. Gilman. It substantially differs?

Dr. Gullattee. Yes.

Mr. Gilman. And I would like to ask the other panelists with regard to their information and how it compares.

Dr. Piccone. Again, there are not gross differences. But it is a matter of how the data is collected. By and large, the Federal data-collecting mechanisms have broken down. At the local level, we still collect information, and share it with the State, which then turns it around and gives it back to us.

But again, we do not have to report to NIDA. And to the extent that that information is shared by the State with the Federal Institute again is not really known to me.

Mr. Robinson. In Boston, Mr. Chairman, in the period of 1980–1982, the Drug Abuse Warning Network at Boston City Hospital, and we see approximately 80 percent of all of the heroin mentions for the Standard Metropolitan Statistical area. There was a 34 percent increase in heroin mentions in 1981–82 over the same period of time in 1979–80 through the emergency room.

At the beginning of 1983, January through June, we had seen a 15-percent increase over the same period of time between January to June of 1982.

In 1982 in September for a period of 6 days, 19 individuals were brought into Boston City Hospital unconscious. Three died. In September of 1983, in a one-and-a-half-day period, I believe it is, nine unconscious bodies were brought in. They were revived, and most left against medical advice.

We had no treatment slots to offer to these individuals. And our doctors and our nurses have to say 30 or 40 times a month: "I am sorry, there is no treatment available."

So they have to go back out, and support that $50-a-day habit or $400-a-day habit, as the case may be until they want treatment or there is treatment available for them.

Mr. Gilman. How much of a backlog do you have awaiting treatment?

Mr. Robinson. For our particular treatment program that we operate in the city of Boston, there is a 3-month waiting list. The average waiting list for programs in Boston, as I said earlier, goes from 3 weeks to 6 months.

Mr. Gilman. A 3-month waiting list.

How many people are on that list?

Mr. Robinson. That is a difficult question to answer. We stop listing at 36 people. We do not take more than 36 on the waiting list. Our waiting list had been as high as 125 to 130 people. But after we get our 36th person, we just say to the next one, we cannot put you on our waiting list.

Mr. GILMAN. Dr. Piccone, do you have the same problem of a waiting list?

Dr. PICCONE. Well, the problem in Philadelphia is somewhat different. We do not have waiting lists, as such. All of our programs are being utilized at approximately 130 percent of the contract matrix, which means that there are any number of program people being asked to provide services to an ever-increasing number of people.

When we talk about a list, we are talking about programs that are attempting to deliver a service with very, very limited resources. So when someone presents himself or herself for treatment, that person is indeed accepted. And again, this is with regard to the methadone maintenance program. The people are put on a methadone maintenance schedule immediately because to do otherwise would put the entire community in jeopardy.

The amount of counseling that goes on becomes very, very limited. And if people are seen once a month, we feel——

Mr. GILMAN. You have no backlog then?

Dr. PICCONE. Not in the true sense of the word, no. It is just a very heavily overutilized system, which I, as the administrator for the county and for the city of Philadelphia, will be forced to make a decision about very, very shortly.

Because I cannot continue to tolerate the potential for the loss of quality of services, with which we are faced. Once that happens, there will literally be hundreds of people out there without any service. We will shut down all admissions.

Mr. GILMAN. Dr. Gullattee, are you faced with a similar problem?

Dr. GULLATTEE. Not to the same magnitude. Generally, it is about 12 to 15 people who are on the waiting list. We purge our system for various violations rather than to maintain people on the rolls. So for the first quarter of 1983, we purged 1000 persons for noncompliance. But then, of course, it places on their ability to come back into the program.

Mr. GILMAN. Do you have any idea of how many you had in the methadone clinic last year?

Dr. GULLATTEE. 2,171. We have a fixed number of slots that we hold for the city.

Mr. GILMAN. And Dr. Piccone, how many did you have in the Philadelphia area on methadone?

Dr. PICCONE. There were 19,000 admissions.

Mr. GILMAN. In 1 year?

Dr. PICCONE. In the substance abuse programs. And we had 5,000 clients admitted for heroin and other opiate abuse.

Mr. GILMAN. And Mr. Robinson?

Mr. ROBINSON. In Boston, there were approximately 900 treatment slots in Greater Boston. But since 1981, there has been a drop because of the funding cutbacks of 11 residential treatment programs, and in the past year the loss of of around 268 treatment slots.

Mr. GILMAN. Roughly, how many would you say that you treated last year in the Boston area?

Mr. ROBINSON. I think that the figure which the division of drug rehabilitation for the State indicates is that there were approximately 3,000 people treated in the Greater Boston area last year.

Mr. GILMAN. I would like to ask the entire panel if you had to sort through your most critical needs to address those to the Congress and to the administration, what would you recommend as your most critical need at the present time?

I know that you have all touched on a number of areas.

What would you touch upon as your most critical need where Congress may be of help, or our committee may be of help, or the administration may be of help to all of you?

And we will start with Dr. Gullattee. You mentioned a number of needs.

What are your more critical needs?

Dr. GULLATTEE. Increased funds for education, prevention, and intervention on the one hand. And on the other, greater service delivery for adolescent and female populations.

Mr. GILMAN. Greater service delivery.

Dr. GULLATTEE. Availability.

Mr. GILMAN. How could we best help in that direction?

Dr. GULLATTEE. By seeking greater funding, so that States can have as a public service short term drug detoxification. And then public outpatient clinics available to those persons once they had been detoxified for both the adolescent population, and for the criminal population, first offenders.

Mr. GILMAN. You also stressed a need for vocational rehabilitation.

Dr. GULLATTEE. Oh, yes.

Mr. GILMAN. Are not any of the existing vocational rehab programs available to municipalities available to your drug people?

Dr. GULLATTEE. It would really depend on where they are, because vocational rehabilitational moneys are not included in service delivery moneys inside of the administration. They are found inside the District, inside the Commission of Social Services.

Mr. GILMAN. Is that a matter of trying to work with another agency, and work out some slots?

Dr. GULLATTEE. Yes. But when you consider that you have 48 percent of a 2,200 population without any jobs or without any means of support, you then have to have more slots than a vocational rehabilitation division would be willing to give you.

We have attempted to ferret out what the Department of Employment Services had available for drug abuse. I understand that there are moneys at the Federal level designated for that particular population.

Mr. GILMAN. It was my impression.

Dr. GULLATTEE. And it is very difficult to find out what that information is in that territoriality.

Mr. GILMAN. If you are having difficulty of that nature, I hope that you will address that in writing, and we will try to help you in that direction.

But you have been able to get some slots assigned, have you not?

Dr. GULLATTEE. Yes.

Mr. GILMAN. And Dr. Piccone.

Dr. **Piccone**. I guess that my statement would be a little more global. I must address the unique situation that large urban centers experience. I want to reiterate to what Mr. Eaton from NASADAD indicated earlier today. And that is the fact that cities are unique.

I would ask that any particular regulation, or restriction, or mandate that is forthcoming that can be effected by this group that impacts on funding allow for there to be local control in large urban settings. It must also allow us (cities) the flexibility to use that particular allocation as we see fit in terms of our planning process.

We do have really different and very unique needs than most other parts of the State that I reside in, and it is very, very much the same in all of the other member cities that make up our national association (NACDAC).

So I think that we need to address some very unique problems with some very specialized mandates.

Mr. **Gilman**. With regard to local control, that was the purpose of the block grant program, to give you better flexibility.

Is that not working out that way?

Dr. **Piccone**. That is not the case at all. In my testimony, I point out just how difficult it has been for Philadelphia to plan and manage its own house, so to speak, because of the way in which the state agency that has control over our funding at this point in time has developed new formulas for dispersing those dollars.

The problem resides at that level. We need a way to manage our own affairs.

Mr. **Gilman**. Is it not something that can be best ironed out with the State government? I recognize that it is a fairly new program, the block grant program. But is that not something that can best be ironed out with your state agencies to provide a more smoother transition of the funds?

Dr. **Piccone**. Only if you can have a conversation that will allow you to begin to develop some meaningful vehicles to do that. And we have not been able to do that.

Mr. **Gilman**. You have not been able to communicate with your State agencies?

Dr. **Piccone**. We communicate with them, but it is primarily a one-way communication network. We have been very, very frustrated in attempting to sit down and discuss these issues. We have sent any number of pieces of correspondence attempting to do that. And it flies in the face of what I consider to be the block grant mandate.

We cannot influence those decisions. We are excluded from committees established by the State that have a direct bearing on block grant funding. An example was a block grant task force where there was no representation from the city of Philadelphia.

We asked the question why not? The response from the State agency director was "It was the Governor's decision." We submitted names in, and he did not select yours. That is not the kind of participatory Government or the processes of Government that we feel are very helpful, especially to the largest city in the Commonwealth suffering the greatest cutbacks in Federal support.

Mr. **Gilman**. I would suggest, Dr. Piccone, that you might want to put that into writing to our committee that you are having difficulty of that nature, and we will see if we can be of help in getting someone to listen.

And Mr. Robinson.

Mr. **Robinson**. I think that for Boston and for the National Association for City Drug and Alcohol Coordination, our particular need would be for an appointment of an executive office level official who can balance the role between supply and demand reduction, and who can respect and represent the special needs of cities and their high risk populations.

I think that from a city standpoint across the country, if that individual was available to us, and had the interest of cities, then I think that we would be progressing far better than we are today.

Mr. **Gilman**. You are thinking of someone in the administration's Office of Special Drug Abuse Policy?

Mr. **Robinson**. For me, and I have been in the drug field since 1970, the best thing that happened to cities was SAODAP, the Special Action Office for Drug Abuse Prevention.

Mr. **Gilman**. Have you had occasion to call upon Dr. Turner's office at all for any help?

Mr. **Robinson**. We asked Dr. Turner, invited Dr. Turner to attend the National Association for City Drug and Alcohol Coordination meeting, and he refused to do so. We brought that to the attention of Mr. Rangel, the chairman, and told him.

As far as Dr. Pollin is concerned, Dr. Pollin, I believe, will not listen to the needs of cities. And Dr. Pollin has been in two administrations. And at the close of the last administration, it was when cities began to have an impact upon Public Law 92-255, whereby we were able to influence Congress so that changes were made in that law, which gave a greater say to cities in the whole planning process.

And, of course, with the block grant, that was all wiped out.

Mr. **Gilman**. I regret that we have a rollcall on before us. We will have to stand in recess for a few minutes. I am sure that the chairman will be returning, and may want to make further inquiry of the existing panel, if the panel would stand by.

And then our additional witnesses, if you would bear with us, we will try to wind it up as quickly as we can. There is a rollcall. It will take us about 10 to 15 minutes.

The committee will now stand in recess until the rollcall is completed.

[Whereupon, a brief recess was taken.]

Mr. **Rangel**. Because of the length of time that the committee questioned, we went far beyond the time allocated to us to complete the hearings. For that reason, I personally will be in touch with the witnesses who did not have an opportunity to testify today.

I want to thank Ms. Joyce Nalepka, who is the senior vice president of the National Federation of Parents for Drug-Free Youth of Washington. We thank you for your presence. And also, Father John McVernon from New York City.

What I will do is ask the staff to get in touch with you so that we could meet sometime this week, and discuss your work. And we can do that with Ben Gilman and myself, Ms. Nalepka.

Then I also would be meeting with the good father in New York in order to try to compensate for what we have done to your schedule.

So I apologize for this. And with your permission, and the committtee's permission, your statements will be entered into the record.

[The statements of Ms. Nalepka and Father McVernon appear on pp. 393 and 402.]

Mr. **Rangel.** And we will be in touch with you to see if we can meet with you privately here. And, Father, after November 18.

The committee will stand adjourned subject to the call of the Chair.

[Whereupon, at 3 p.m., the select committee was adjourned subject to the call of the Chair.]

[The following was received for the record:]

SUBMISSIONS FOR THE RECORD

ACTION
WASHINGTON, D.C. 20525

January 13, 1984

Honorable Charles B. Rangel
Chairman
Select Committee on Narcotics Abuse
and Control
U.S. House of Representatives
Room H2-234, House Office Building
Annex 2
Washington, D.C. 20515

Dear Mr. Chairman:

Thank you for allowing us the additional time necessary to answer your Committee's questions. Please find enclosed ACTION's response to the follow-up questions from the November 2, 1983 hearing by the Select Committee on Narcotics Abuse and Control concerning drug abuse prevention programs.

I appreciated the opportunity to appear before your Committee. Thank you for your cooperation.

Sincerely,

Tom Pauken

Thomas W. Pauken
Director

QUESTION 1

Please submit for the record a complete listing of drug prevention projects and initiatives funded by ACTION for fiscal year 1982 and a seperate list for 1983. For each project indicate the amount received and give a brief description of the activities supported by ACTION funds. In addition, please indicate whether the project is a demonstration grant or a project supported by ACTION volunteers (e.g. VISTA volunteers, Retired Senior Volunteers, Young Volunteers in ACTION, etc.,) and in the case of the latter, indicate the number of volunteers supported.

QUESTION 1

Demonstration Grants

The following are listings of demonstration grants for FY's 1981, 1982, and 1983. Each includes a short description of the projects and dollar amounts.

ACTION DRUG PREVENTION PROGRAM DEMONSTRATION GRANTS FY 1981

DARE (DRUGS/ALCOHOL/REHABILITATION/EDUCATION) PROGRAM ARCHDIOCESE OF NEW YORK	51,700

Development of a comprehensive, community-based model with adult and youth components geared to the utilization of volunteers in prevention, education, and early intervention services to an estimated 236,000 youthful beneficiaries throughout a ten-county project area. Support of 3,500 volunteers in service at some 750 volunteer stations, including public, private, and parochial schools, parishes, and public/private institutions and organizations.

ACTION DRUG PREVENTION PROGRAM DEMONSTRATION GRANTS FY 1982

Parent Resources and Information for Drug Education

235,462

PRIDE has established, with the help of this grant, a National Family Resource Center on drug education. Its components include a toll-free number, packets of materials distributed to callers, development of updated resources on specific drugs, issues, and methodologies, the annual PRIDE conference in Atlanta, and a 24-hour teletape machine capable of playing tapes on a variety of drug and alcohol-related topics.

FAMILIES IN ACTION

43,920

This grant enabled Families in Action to provide informational services to a wide audience of educators, parents and libraries throughout the country. FIA distributes a manual entitled How to Form a Families in Action Group in Your Community and publishes Drug Abuse Update, a topical newsletter distributed nation-wide.

National Federation of Parents for Drug Free Youth

20,015

A grant was awarded to NFP for their first national conference. In order to ensure the success of the conference, the grant helped to complete the organizational responsibilities, provide travel, registration fees for presenters, and purchase booklets and materials that were given to those who attended.

OHIO FEDERATION OF FAMILIES FOR DRUG FREE YOUTH

19,500

The Ohio Federation of Familieis for Drug Free Youth is forming a state network of parent/community groups and individuals that will provide educational information, technical assistance, and an opportunity for sharing experiences and ideas that would enable them to progress in their curtailment of drug and alcohol use by youth.

COLORADO IN ACTION FOR DRUG FREE YOUTH

9,280

During FY 1982, support was given to a coalition of groups in Colorado for the "1982 Colorado Conference on Drug Free Youth." Additionally, funds were transfered to the ACTION Regional office in Denver for the purchase of 10 films, all of which are being checked out by various groups throughout the state on a constant basis. Both of these activities have aided tremendously in the development of a drug prevention movement in Colorado.

NATIONAL CITIZENS PARTICIPATION COUNCIL

9,900

This project conducted a survey of local programs for youth in the areas of alcohol and drug abuse found in minority communities and neighborhood enterprises. Ten communities were selected which have successful self-help volunteer programs. On site and telephone surveys were conducted.

AMERICAN COUNCIL ON MARIJUANA	51,463

The American Council on Marijuana (now the Council on Drug Education, CDE) used this grant to condense information contained in their scientific monographs into brochures for distribution to parent groups that have formed in order to address the problem of drug abuse in their communities. CDE also wrote the materials used by the McNeil Pharmaceutical Company for the Pharmacists Against Drug Abuse Campaign and have developed, along with PRIDE-Omaha a handbook for leaders of youth groups.

ACTION DRUG PREVENTION PROGRAM DEMONSTRATION DARE GRANTS FY 1983

OREGON FREE FROM DRUG ABUSE 30,000

Oregon Free From Drug Abuse mobilizes parents and other concerned adults to protect children from the use of psychoactive drugs by forming grassroots parents groups, and, once they're organized, by stimulating these groups into action through the systematic dissemination of information from their Drug Information Center.

PARENTS IN ACTION IN NEBRASKA (P.A.N.) 29,963

PAN will develop new parent community groups in target areas and mobilize a state-wide network of new and existing parent groups in order to create a drug free environment for youth in Nebraska through positive parent power and attitude.

FAMILIES IN ACTION OF BERNALILLO COUNTY 29,909

Families in Action will network the state of New Mexico for the purpose of establishing parent groups to deal with the problems of drug abuse among our youth. The program includes a state-wide conference.

INDIANA FEDERATION OF COMMUNITIES FOR DRUG FREE YOUTH 20,656

Ojectives of the Indiana Federation of Communities include:

1. Establish a permanent Federation networking office to formally network 85+ parent/community groups in the state.
2. Conduct state-wide "Training Volunteer Trainers, Prevention Workshop," utilizing Stephen Glenn's "Developing Capable People" and "Strengthening the Family."
3. Form a Volunteer Traveling Panel to assist in the development of drug prevention programs.

TENNESSEEANS AGAINST DRUGS 26,712

Tennesseans Against Drugs is a project which will establish a state-wide network of parent groups in Tennessee in order to educate parents about drugs, to involve the total community in a drug prevention program and to provide alternatives for youth to eliminate their "first use" of drugs.

FLORIDA INFORMED PARENTS 18,940

Florida Informed Parents is a program designed to network the efforts of 84 parent groups in the state of Florida in combating the problem of adolescent drug use. These groups involve the services of hundreds of volunteers in their programs. F.I.P. also offers start up assistance to newly emerging groups in the state.

ACTION DRUG PREVENTION PROGRAM DEMONSTRATION GRANTS FY 1983

page 2

OPERATION PAR, FLORIDA 10,000

Operation PAR used this grant to organize and present "Community Responses to Drug Abuse: Prevention Strategies for the 80's," a state-wide conference on drug prevention strategies which involved youth as well as adults.

COUNCIL ON PREVENTION AND EDUCATION: SUBSTANCES (COPES), KENTUCKY 19,094

COPES' objectives are to identify, assist, and support the volunteer drug use prevention movement in Kentucky through networking and regional conferences to be attended by parents and other concerned citizens.

MISSOURI FEDERATION OF PARENTS FOR DRUG FREE YOUTH 29,700

The Missouri Federation of Parents for Drug Free Youth is developing and mobilizing a state-wide network of parent groups to deal with the special problems of youth in the community through state-wide networking activities and an MFP conference.

NORTH CAROLINIANS AGAINST DRUG AND ALCOHOL ABUSE 30,000

North Carolinians Against Drug and Alcohol Abuse is a non-profit organization aimed at educating the public about the symptoms and impact of drug and alcohol abuse, emphasizing youth, through supporting drug prevention programs, parent groups and community groups throughout the state. NCADAA organized a conference dealing with prevention during the fall of 1983.

CALIFORNIANS FOR DRUG FREE YOUTH 40,445

Californians for Drug Free Youth is establishing a network of local parent and community groups in California to deal with the problems of drug and alcohol abuse among youth at a local and state level. Californians for Drug Free Youth are also planning a second major conference (the first, in Los Angeles was held in the fall of 1983) for the spring of 1984 in Sacramento.

DARE PROGRAM--ARCHDIOCESE OF MIAMI FIELD TEST 26,999

This grant supports six months of the DARE model implementation and field-testing.

DARE PROGRAM--ARCHDIOCESE OF NEW YORK 51,700

This is a continuation of the 1981 grant.

PRIDE	167,815

This is a continuation of the 1982 grant with the addition of a youth service component called "STRIDE," Student Resource Institute for Drug Education.

FAMILIES IN ACTION	31,330

This is a continuation of the 1982 grant.

QUESTION 1

VISTA

The following are listings of VISTA projects which emphasize alcohol/drug abuse prevention, education, and, in some cases, treatment, for FY1982 and FY1983. Also included is a projection for alcohol/drug-related VISTAs for FY1984.

Each list is broken down by ACTION region, project, number of slots approved, and number of volunteers actually on-board.

ALCOHOL/DRUG ABUSE PROJECTS
(as of 9/30/82)

Region	Sponsor	Approved Slots	# of Vols On-Board
I	Danbury Youth Services, Inc. Danbury, CT	1	1
	Connecticut Dept of Corrections Hartford, CT	10	7
	YMCA of Greater New Haven New Haven, CT	6	3
	Youth Services Bureau of New Haven New Haven, CT	10	8
	Child & Family Services, Inc. Torrington, CT	5	4
	Mission Hill American Legion Post #327 Boston, MA	7	6
	Survival, Inc. Quincy, MA	8	5
	Newton Community Service Centers, Inc. West Newton, MA	6	5
	Tribal Governors Inc. Orono, ME	4	4
	N.H. Office of Alcohol & Drug Abuse Prevention Concord, NH	10	9
	Nashva Adult Learning Center Nashva, NH	3	1
	Marathon House, Inc. Providence, RI	8	4
	Total	78	57

ALCOHOL/DRUG ABUSE PROJECTS
(as of 9/30/82)

Region	Sponsor	Approved Slots	# of Vols On-Board
II	Camden County Alcohol Abuse Program Camden, NJ	10	5
	Odyssey House, Inc. New York, NY	20	4
	Congregation of Mothers of the Sacred Heart Santurce, PR	20	10
	P.R. Department of Education School Health Program Hato Rey, PR	15	14
	Hogares C.R.E.A., Inc. Trujillo Alto, PR	18	15
	Total	83	48

ALCOHOL/DRUG ABUSE PROJECTS
(as of 9/30/82)

Region	Sponsor	Approved Slots	# of Vols On-Board
III	Jones Fall Community Corporation Baltimore, MD	10	2
	Catholic Social Services of Fostoria Fostoria, OH	6	6
	County of Dauphin, Dept. of Human Services Harrisburg, PA	14	12
	Alcohol & Drug Abuse Preventive/ Training Service Richmond, VA	6	1
	Total	36	21

ALCOHOL/DRUG ABUSE PROJECTS
(as of 9/30/82)

Region	Sponsor	Approved Slots	# of Vols On-Board
IV	Alethia House Inc. Birmingham, AL	5	24
	Alabama Dept. of Mental Health Montgomery, AL	10	4
	Alachua County Center for Voluntary Action, Inc. Gainesville, FL	12	4
	Thee Door of Central Florida, Inc. Orlando, FL	8	4
	Volunteer Services Bureau Orlando, FL	6	5
	Georgia Mountains APDC Gainsville, GA	1	1
	Senior Citizens of Savannah-Chatham County, Inc. Savannah, GA	1	1
	Farish Street YMCA Jackson, MS	5	5
	Jackson Municipal Separate School District Jackson, MS	9	9
	S.C. Commission on Alcohol & Drug Abuse Columbia, SC	10	9
	Total	67	66

ALCOHOL/DRUG ABUSE PROJECTS
(as of 9/30/82)

Region	Sponsor	Approved Slots	# of Vols On-Board
V	West Indianapolis Neighborhood Congress, Inc. Indianapolis, IN	1	1
	Near Eastside Multi-Service Center, Inc. Indianapolis, IN	2	2
	Total	3	3

ALCOHOL/DRUG ABUSE PROJECTS
(as of 9/30/82)

Region	Sponsor	Approved Slots	# of Vols On-Board
VI	Kansas Children's Service League Topeka, KS	3	3
	East Side Human Resource Center St. Joseph, MO	4	4
	Total	7	7

ALCOHOL/DRUG ABUSE PROJECTS
(as of 9/30/82)

Region	Sponsor	Approved Slots	# of Vols On-Board
VIII	Montana Inter-Tribal Policy Board Billings, MT	6	3
	Big Brothers & Sisters of Helena Helena, MT	20	15
	Total	26	18

ALCOHOL/DRUG ABUSE PROJECTS
(as of 9/30/82)

Region	Sponsor	Approved Slots	# of Vols On-Board
IX	County of San Luis Obispo Mental Health Department San Luis Obispo, CA	5	4
	Alu Like Honolulu, HI	10	8
	American Red Cross - Division of Youth Services Honolulu, HI	7	6
	Youth Services Division - State of Nevada Carson City, NV	20	13
	Clark County Juvenile Court Services Las Vegas, NV	16	10
	Total	58	41

ALCOHOL/DRUG ABUSE PROJECTS
(as of 9/30/82)

Region	Sponsor	Approved Slots	# of Vols On-Board
X	Silver Valley Alcohol Rehabilitation Kellogg, ID	2	2
	Total	2	2

Grand Total: Projects - 43
Approved Slots - 300
# of Vols On-Board - 263

Alcohol/Drug Projects
(as of 9/30/83)

Region	Sponsor	Approved Slots	# of Vols
I	N.H. Office of Alcohol & Drug Abuse Prevention Concord, NH	8	10
	Marathon House, Inc. Providence, RI	4	5
	Drug Rehabilitation, Inc. Bar Mills, ME	4	3
	Danbury Youth Services, Inc. Danbury, CT	1	1
	Connecticut Alcohol & Drug Abuse Commission Hartford, CT	6	0
	Total	23	19

Alcohol/Drug Projects
(as of 9/30/83)

Region	Sponsor	Approved Slots	# of Vols
II	Camden County Alcohol Abuse Program Camden, NJ	4	1
	Odyssey House, Inc. New York, NY	4	4
	Puerto Rico Department of Education Hato Rey, PR	15	1
	Hogares CREA, Inc.	14	13
	Dept. of Education-Archdiocese of New York New York, NY	10	0
	Total	47	19

Alcohol/Drug Projects
(as of 9/30/83)

Region	Sponsor	Approved Slots	# of Vols
III	Alcohol & Drug Abuse Prevention & Training Services (ADAPTS) Richmond, VA	2	2
	Northern Panhandle Behavioral Health Center Wheeling, WV	2	2
	Total Action Against Poverty Roanoke, VA	6	2
	Jefferson Alcohol & Drug Abuse Center Louisville, KY	4	3
	Breckinridge-Grayson Programs, Inc. Leitchfield, KY	4	2
	North Toledo Area Corporation Toledo, OH	6	5
	Department of Community Services Bel Air, MD	3	0
	County of Dauphin - Dept. of Human Services	14	5
	City of Portsmouth Portsmouth, VA	3	3
	Total	47	22

Alcohol/Drug Projects
(as of 9/30/83)

Region	Sponsor	Approved Slots	# of Vols
IV	Alethia House, Inc. Birmingham, AL	5	2
	Alabama Dept. of Mental Health Montgomery, AL	33	28
	Thee Door of Central Florida, Inc. Orlando, FL	8	8
	Senior Citizens Savannah-Chatham County, Inc. Savannah, GA	2	4
	S.C. Commission on Alcohol & Drug Abuse Columbia, SC	14	7
	Tennessee Association of Alcohol & Drug Council Clearinghouse Nashville, TN	3	1
	Council on Drug Abuse Winston-Salem, NC	4	3
	Lumbee Regional Development Association Pembroke, NC	8	8
	LBJ&C Development Corporation Monterey, TN	6	0
	E.S. Inc. Rape House/Oasis House Nashville, TN	5	3
	N.C. Commission of Indian Affairs Raleigh, NC	10	4
	Senior Citizens Service of Metro-Atlanta Atlanta, GA	6	6
	Jefferson County Committee for Economic Opportunity Birmingham, AL	5	2
	North Carolinians Against Drug & Alcohol Abuse Raleigh, NC	20	0
	Total	134	81

Alcohol/Drug Projects
(as of 9/30/83)

Region	Sponsor	Approved Slots	# of Vols
V	DOVE Decatur, IL	10	5
	West Indianapolis Neighborhood Congress, Inc. Indianapolis, IN	1	0
	Woodlawn Ministerial Alliance Chicago, IL	6	6
	Near Eastside Multi-Service Center, Inc. Indianapolis, IN	4	3
	Alternatives, Inc. Chicago, IL	6	6
	Hermosa Area Neighbors Association Chicago, IL	7	4
	Indian Youth of America Sioux City, IA	2	0
	Total	36	24

Alcohol/Drug Projects
(as of 9/30/83)

Region	Sponsor	Approved Slots	# of Vols
VI	Family Self-Help Center Joplin, MO	8	7
	SERVE, Inc. Fulton, MO	4	3
	Crowley's Ridge Development Council, Inc. Jonesboro, AR	5	3
	Big Brothers/Big Sisters of Springfield Springfield, MO	1	1
	Total	18	14

Alcohol/Drug Projects
(as of 9/30/83)

Region	Sponsor	Approved Slots	# of Vols
VIII	Inter-Tribal Alcoholism Treatment Center Sheridan, WY	7	6
	Touchstone Community Alcohol & Drug Abuse Services Norfolk, NE	6	5
	Mountain Plains Youth Service Coalition Pierre, SD	7	5
	Community & Youth Involved, Inc. Ft. Pierre, SD	2	2
	Awareness House Training & Development Systems, Inc. Denver, CO	15	0
	Total	37	18

Alcohol/Drug Projects
(as of 9/30/83)

Region	Sponsor	Approved Slots	# of Vols
IX	San Luis Obispo County Mental Health Department San Luis Obispo, CA	3	4
	Alu Like, Inc. Honolulu, HI	2	3
	Chicanos Por La Causa Phoenix, AZ	10	4
	American Red Cross Honolulu, HI	4	4
	Operation Bridge Las Vegas, NV	1	0
	Total	18	18

Alcohol/Drug Projects
(as of 9/30/83)

Region	Sponsor	Approved Slots	# of Vols
X	Small Tribes of Western Washington Sumner, WA	10	9
	Silver Valley Alcoholic Rehabilitation Center, Inc. Kellogg, ID	2	2
	Center for Adolescent Development Research & Education McMinnville, OR	3	0
	Total	15	11

Grand Total: Projects - 58
Approved Slots - 375
Volunteers On-Board - 226

VISTA FY 1984 DRUG ABUSE PROJECTS
(Based on CYOP projections for 9/30/84)

Region	# of Projects	# of Vols Assigned
I	12	25
II	6	24
III	11	40
IV	0	0
V	7	19
VI	2	5
VIII	7	20
IX	9	22
X	4	6
Total	58	161

QUESTION 1

Older American Volunteer Programs

This section has been broken down into three parts, reflecting the three Older American Volunteer programs supported by ACTION: the Retired Senior Volunteer Program (RSVP), the Foster Grandparent Program (FGP), and the Senior Companion Program (SCP). Below is a brief explanation of their involvement in the Drug Prevention Program, followed by lists of projects which emphasize drug abuse within the three programs.

Retired Senior Volunteer Program

The Retired Senior Volunteer Program is the OAVP program that has the greatest flexibility in terms of the role of the volunteer. This flexibility is in large part the reason we have seen such a dramatic increase in the involvement of older American volunteers in the area of drug abuse. In FY1982, 1,994 RSVP volunteers were volunteering in the area of drug abuse. By FY1984, we project that number will rise to 5,337. RSVP volunteers are involved in all aspects of drug and alcohol prevention and, in some cases, treatment. As of now, 121 RSVP projects report emphasizing this kind of service.

Foster Grandparent Program

Distributed over 35 projects nation-wide, Foster Grandparents provided 746 volunteer service years in FY1982 and 808 service years in FY1983 in the area of drug abuse. Foster Grandparents provide supportive services, on a one-to-one basis, to children with exceptional or special needs. In settings which include juvenile courts, correctional institutions, hospitals, group homes, social service agencies, and private homes, Foster Grandparents support the direction and efforts of the professional treatment staff and provide the child with the support and caring they so often so desperately need.

Senior Companion Program

Senior Companions provide supportive person-to-person services to primarily older adults. As such, the focus of SCP's involvement in the area of drug abuse lies in the prevention of the misuse of over-the-counter, prescription drugs by seniors. The Senior Companion Program has funded seven drug abuse project components. Additionally, all Senior Companion project directors and volunteers have received extensive training in the area of drug abuse. There are currently 28 projects emphasizing this service.

There are 184 OAVP projects that are active in the service area of drug abuse. These projects are in the full spectrum of prevention and treatment services throughout the communities in which they serve.

RSVP
Alcohol/Drug Abuse

PROJECT LOCATOR BY VOLUNTEER ACTIVITY
SUB-CATEGORY CODE 113

EMPHASIS CODE	REGION	STATE	PROJECT NAME CITY
1	01	VT	RETIRED SENIOR VOLUNTEER PROGRAM OF CENTRAL VT BARRE
1	02	NJ	RSVP OF CAMDEN COUNTY CAMDEN
1	02	NJ	RSVP OF MORRIS COUNTY INC MORRIS PLAINS
1	03	MD	PRINCE GEORGES COUNTY RETIRED SENIOR VOLUNTEER PGM HYATTSVILLE
1	03	OH	RSVP OF THE MIAMI VALLEY GREENVILLE
1	03	OH	RETIRED SENIOR VOLUNTEER PROGRAM MANSFIELD
1	03	PA	RSVP PROJECT FREDERICKTOWN
1	03	VA	RETIRED SENIOR VOLUNTEER PROGRAM GATE CITY
1	03	VA	RSVP SEVAMP SENIOR SERVICES NORFOLK
1	04	AL	RSVP LAUDERDALE COUNTY FLORENCE
1	04	AL	ETOWAH COUNTY RSVP GADSDEN
1	04	TN	RSVP DYERSBURG
1	04	TN	RETIRED SENIOR VOLUNTEER PROGRAM LEXINGTON
1	04	TN	RETIRED SENIOR VOLUNTEER PROGRAM MCMINNVILLE
1	05	IA	CLARINDA RSVP PROGRAM CLARINDA
1	05	IL	RETIRED SENIOR VOLUNTEER PROGRAM BENSENVILLE
1	05	MI	RSVP OF KALAMAZOO COUNTY KALAMAZOO

PROJECT LOCATOR BY VOLUNTEER ACTIVITY
SUB-CATEGORY CODE 113

EMPHASIS CODE	REGION	STATE	PROJECT NAME CITY
1	05	WI	NORTHWEST RSVP ASHLAND
1	06	LA	RETIRED SENIOR VOLUNTEER PROGRAM LAKE CHARLES
1	06	MO	GRUNDY COUNTY RETIRED SENIOR VOLUNTEER PROGRAM TRENTON
1	06	OK	RETIRED SENIOR VOLUNTEER PROGRAM ARDMORE
1	06	OK	RSVP OF OKLAHOMA COUNTY INC OKLAHOMA CITY
1	06	TX	HARLINGEN RSVP HARLINGEN
1	08	CO	SAN LUIS VALLEY RSVP ALAMOSA
1	08	MT	WOLF POINT RETIRED VOLUNTEER PROGRAM WOLF POINT
1	08	NE	CRAWFORD RETIRED SENIOR VOLUNTEER PROGRAM CRAWFORD
1	08	NE	EASTERN NEBRASKA RSVP OMAHA
1	08	NE	SCOTTS BLUFF COUNTY VOLUNTEER BUREAU SCOTTS BLUFF
1	08	NE	INTER TRIBAL RETIRED SENIOR VOLUNTEER PROGRAM WINNEBAGO
1	08	SD	RSVP MITCHELL
1	08	UT	CARBON COUNTY RETIRED SENIOR VOLUNTEER PROGRAM EAST CARBON
1	09	CA	RETIRED SENIOR VOLUNTEER PROGRAM SAN FRANCISCO
1	09	CA	RETIRED SENIOR VOLUNTEER PROGRAM SANTA ANA
1	09	NV	RSVP CARSON CITY

PROJECT LOCATOR BY VOLUNTEER ACTIVITY
SUB-CATEGORY CODE 113

EMPHASIS CODE	REGION	STATE	PROJECT NAME CITY
1	10	OR	RSVP OF LANE COUNTY EUGENE
1	10	WA	RETIRED SENIOR VOLUNTEER PROGRAM LONGVIEW
1	10	WA	WALLA WALLA COUNTY RSVP INC WALLA WALLA

PROJECT LOCATOR BY VOLUNTEER ACTIVITY
SUB-CATEGORY CODE 113

EMPHASIS CODE	REGION	STATE	PROJECT NAME CITY
2	01	NH	MERRIMACK COUNTY RSVP CONCORD
2	01	NH	CARROLL COUNTY RETIRED SENIOR VOLUNTEER PROGRAM N CONWAY
2	01	VT	RETIRED SENIOR VOLUNTEER PROGRAM BURLINGTON
2	02	NJ	RSVP OF MONMOUTH LONG BRANCH
2	02	NJ	RSVP OF SUSSEX COUNTY NEWTON
2	02	NJ	PASSAIC COUNTY RETIRED SENIOR VOLUNTEER PROGRAM PATERSON
2	02	NJ	RSVP OF WARREN COUNTY PHILLIPSBURG
2	02	NJ	RSVP GLOUCESTER COUNTY COLLEGE SEWELL
2	02	NJ	RSVP WILLINBORO
2	02	NY	RETIRED SENIOR VOLUNTEER PROGRAM OF ORANGE COUNTY GOSHEN
2	02	NY	CHAUTAUQUA COUNTY JAMESTOWN
2	02	PR	RETIRED SENIOR VOLUNTEER PROGRAM SANTURCE
2	03	MD	RETIRED SENIOR VOLUNTEER PROGRAM GLEN BURNIE
2	03	OH	MARIETTA WASHINGTON COUNTY RSVP MARIETTA
2	03	OH	RETIRED SENIOR VOLUNTEER PROGRAM NEW LEXINGTON
2	03	PA	RSVP ERIE
2	03	PA	TRI-COUNTY RETIRED SENIOR VOLUNTEER PROGRAM HARRISBURG

PROJECT LOCATOR BY VOLUNTEER ACTIVITY
SUB-CATEGORY CODE 113

EMPHASIS CODE	REGION	STATE	PROJECT NAME CITY
2	03	PA	RSVP PHILADELPHIA WEST PHILADELPHIA
2	04	AL	RETIRED SENIOR VOLUNTEER PROGRAM EUFAULA
2	04	FL	RETIRED SENIOR VOLUNTEER PROGRAM BRADENTON
2	04	FL	RSVP DAYTONA BEACH
2	04	FL	RETIRED SENIOR VOLUNTEER PROGRAM TAMPA
2	04	GA	RSVP COLUMBUS GEORGIA COLUMBUS
2	04	GA	RETIRED SENIOR VOLUNTEER PROGRAM TRENTON
2	04	MS	RETIRED SENIOR VOLUNTEER PROGRAM COLUMBIA
2	04	NC	CHAPEL HILL-ORANGE COUNTY RSVP CHAPEL HILL
2	04	NC	RSVP LILLINGTON
2	04	NC	RETIRED SENIOR VOLUNTEER PROGRAM WILMINGTON
2	04	TN	RETIRED SENIOR VOLUNTEER PROGRAM MONTEREY
2	05	IA	WINNESHIEK COUNTY CROSSLINES COUNCIL RSVP DECORAH
2	05	IA	RETIRED SENIOR VOLUNTEER PROGRAM DUBUQUE
2	05	IA	GLENWOOD RETIRED SENIOR VOLUNTEER PROGRAM GLENWOOD
2	05	IA	RSVP NEWTON
2	05	IA	RETIRED SENIOR VOLUNTEER PROGRAM WATERLOO

PROJECT LOCATOR BY VOLUNTEER ACTIVITY
SUB-CATEGORY CODE 113

EMPHASIS CODE	REGION	STATE	PROJECT NAME CITY
2	05	IL	RETIRED SENIOR VOLUNTEER PROGRAM FREEPORT
2	05	IL	RETIRED SENIOR VOLUNTEER PROGRAM JOLIET
2	05	IL	PENINSULA RETIRED SENIOR VOLUNTEER PROGRAM KARNAK
2	05	IL	RSVP PEORIA
2	05	IL	RETIRED SENIOR VOLUNTEER PROGRAM SPRINGFIELD
2	05	IN	RSVP OF ELKHART COUNTY ELKHART
2	05	IN	RETIRED SENIOR VOLUNTEER PROGRAM INDIANAPOLIS
2	05	MI	RETIRED SENIOR VOLUNTEER PROGRAM ESCANABA
2	05	MI	RETIRED SENIOR VOLUNTEER PROGRAM FLINT
2	05	MI	INKSTER RETIRED SENIOR VOLUNTEER PROGRAM INKSTER
2	05	MN	DULUTH AREA RSVP DULUTH
2	06	AR	UNION COUNTY RETIRED SENIOR VOLUNTEER PROGRAM EL DORADO
2	06	AR	STUTTGART-NORTH ARKANSAS COUNTY RSVP STUTTGART
2	06	KS	RETIRED SENIOR VOLUNTEER PROGRAM DODGE CITY
2	06	KS	FINNEY COUNTY RETIRED SENIOR VOLUNTEER PROGRAM GARDEN CITY
2	06	KS	RSVP MISSION
2	06	KS	RETIRED SENIOR VOLUNTEER PROGRAM PRATT

PROJECT LOCATOR BY VOLUNTEER ACTIVITY
SUB-CATEGORY CODE 113

EMPHASIS CODE	REGION	STATE	PROJECT NAME	CITY
2	06	MO	LIVINGSTON COUNTY RSVP	CHILLICOTHE
2	06	MO	SPRINGFIELD GREEN COUNTY RSVP	SPRINGFIELD
2	06	NM	LOS ALAMOS RSVP	LOS ALAMOS
2	06	OK	LITTLE DIXIE RSVP	ANTLERS
2	06	OK	BRYAN COUNTY RETIRED SENIOR VOLUNTEER PROGRAM	DURANT
2	06	OK	LAWTON RETIRED SENIOR VOLUNTEER PROGRAM	LAWTON
2	06	TX	RETIRED SENIOR VOLUNTEER PROGRAM	AMARILLO
2	06	TX	CENTRAL TEXAS RETIRED SENIOR VOLUNTEER PROGRAM	BELTON
2	06	TX	RSVP	NEDERLAND
2	06	TX	CENTRAL PLAINS RSVP	PLAINVIEW
2	06	TX	RETIRED SENIOR VOLUNTEER PROGRAM	SAN ANOTONIO
2	06	TX	RSVP	TULIA
2	06	TX	RSVP	VICTORIA
2	08	CO	PUEBLO COUNTY RSVP	PUEBLO
2	08	CO	RSVP OF JEFFERSON COUNTY	WHEAT RIDGE
2	08	MT	RETIRED SENIOR VOLUNTEER PROGRAM	BILLINGS
2	08	MT	RSVP	ROUNDUP

PROJECT LOCATOR BY VOLUNTEER ACTIVITY
SUB-CATEGORY CODE 113

EMPHASIS CODE	REGION	STATE	PROJECT NAME CITY
2	08	NE	RICHARDSON COUNTY RSVP FALLS CITY
2	08	NE	RETIRED SENIOR VOLUNTEER PROGRAM BUFFALO COUNTY KEARNEY
2	08	SD	RETIRED SENIOR VOLUNTEER PROGRAM RAPID CITY
2	08	UT	RSVP OF WEBER COUNTY OGDEN
2	08	UT	RETIRED SENIOR VOLUNTEER PROGRAM PROVO
2	09	CA	RSVP NOC FULLERTON
2	09	CA	RSVP SANTA BARBARA SANTA BARBARA
2	09	NV	RSVP LAS VEGAS
2	09	NV	WASHOE RETIRED SENIOR VOLUNTEER PROGRAM RENO
2	10	AK	THE RSVP PROJECT OF TEXARKANA ARKANSAS TEXARKANA
2	10	AK	THE RSVP PROJECT OF TEXARKANA TEXAS TEXARKANA
2	10	ID	LEWIS-CLARK RETIRED SENIOR VOLUNTEER PROGRAM LEWISTON
2	10	OR	RETIRED SENIOR VOLUNTEER PROGRAM RSVP GOLD BEACH
2	10	WA	RETIRED SENIOR VOLUNTEER PROGRAM ABERDEEN
2	10	WA	RETIRED SENIOR VOLUNTEER PROGRAM BELLINGHAM
2	10	WA	KING COUNTY RSVP SEATTLE

Note: The Senior Companion Program has funded seven projects to develop specific drug components. They include:

SCP of Washington County
Macias, ME 04654

Age Center of Worcester
Worcester, MA 01609

Blair County Office of Services for the Aging
Altoona, PA 16601

Hawkeye Institute of Technology
Waterloo, IA 50704

Association of Retarded Citizens/Minnesota
Minneapolis, MN 55408

Eastern Nebraska Office on Aging
Omaha, Nebraska 68114

Lutheran Social Services of North Dakota
Fargo, ND 58107

Again, all Senior Companions have received extensive training in the area of drug abuse. A listing follows of all SCP projects which have identified drug abuse as a major or minor emphasis.

PROJECT LOCATOR BY VOLUNTEER ACTIVITY
SUB-CATEGORY CODE 113

EMPHASIS CODE	REGION	STATE	PROJECT NAME CITY
1	01	MA	SENIOR COMPANION PROGRAM WORCESTER
1	03	PA	SENIOR COMPANION PROGRAM SCRANTON
1	04	FL	GRANDPEOPLE, INC TALLAHASSEE
1	05	MN	SENIOR COMPANION PROGRAM MINNEAPOLIS
1	08	MT	TRI COUNTY SENIOR COMPANION PROGRAM HELENA
1	08	WY	WYOMING SENIOR COMPANION PROGRAM CASPER
1	09	CA	CITY OF SAN BERNARDINO SENIOR COMPANION PROGRAM SAN BERNARDINO
1	09	NV	SENIOR COMPANION PROGRAM LAS VEGAS
1	10	OR	LINCOLN COUNTY SCP NEWPORT

PROJECT LOCATOR BY VOLUNTEER ACTIVITY
SUB-CATEGORY CODE 113

EMPHASIS CODE	REGION	STATE	PROJECT NAME CITY
2	01	MA	SCP LOWELL
2	01	ME	SENIOR COMPANION PROGRAM ORONO
2	01	NH	BELKNAP-MERRIMACK COMMUNITY ACTION PROGRAM CONCORD
2	02	NJ	SENIOR COMPANIONS JERSEY CITY
2	02	NY	ERIE SCP BUFFALO
2	02	NY	NIAGARA SCP NIAGARA FALLS
2	03	DE	SENIOR COMPANION PROGRAM GEORGETOWN
2	04	AL	SENIOR COMPANION PROGRAM OF MOBILE COUNTY MOBILE
2	04	FL	SENIOR COMPANION PROGRAM MIAMI
2	04	GA	SENIOR COMPANION PROGRAM SAVANNAH
2	04	TN	VAN BUREN COMMUNITY DEVELOPMENT & SERVICES BD SPENCER
2	05	MI	SENIOR COMPANION PROGRAM OF OAKLAND COUNTY FARMTN HILLS
2	06	MO	SENIOR COMPANION PROGRAM OF KANSAS CITY, MISSOURI KANSAS CITY
2	06	MO	PHELPS COUNTY SENIOR COMPANION PROGRAM ROLLA
2	08	ND	SENIOR COMPANION PROGRAM FARGO
2	08	NE	SCP OF EASTERN NEBRASKA OFFICE ON AGING OMAHA
2	10	OR	SCP OF LANE COUNTY EUGENE

PROJECT LOCATOR BY VOLUNTEER ACTIVITY
SUB-CATEGORY CODE 113

EMPHASIS CODE	REGION	STATE	PROJECT NAME CITY
2	10	WA	GRAYS HARBOR SENIOR COMPANION PROGRAM ABERDEEN
2	10	WA	SENIOR COMPANION PROGRAM YAKIMA

PROJECT LOCATOR BY VOLUNTEER ACTIVITY
SUB-CATEGORY CODE 113

EMPHASIS CODE	REGION	STATE	PROJECT NAME CITY
1	00		FOSTER GRANDPARENT PROGRAM LAC DU FLAMBEAU
1	02	NY	BROOME COUNTY FOSTER GRANDPARENT PROGRAM BINGHAMTON
1	02	NY	NEW YORK CITY FOSTER GRANDPARENT PROGRAM NEW YORK
1	02	NY	FOSTER GRANDPARENT PROGRAM ROCHESTER
1	03	DC	FOSTER GRANDPARENT PROGRAM WASHINGTON
1	03	MD	FOSTER GRANDPARENT PROGRAM BALTIMORE
1	03	OH	AKRON SUMMIT COMMUNITY ACTION AGENCY FGPROGRAM AKRON
1	05	MN	FOSTER GRANDPARENT PROGRAM MINNEAPOLIS
1	05	MN	FOSTER GRANDPARENT PROGRAM ST CLOUD
1	06	KS	KANSAS CITY KANSAS FGP PROGRAM KANSAS CITY
1	06	NM	NEW MEXICO YOUTH WORK ALLIANCE FGP ALBUQUERQUE
1	06	NM	LAS CRUCES FOSTER GRANDPARENT PROGRAM LAS CRUCES
1	08	NE	PANHANOLE FOSTER GRANDPARENT PROGRAM SCOTTSBLUFF
1	09	CA	FOSTER GRANDPARENT PROGRAM SOQUEL
1	09	CA	FRED C NELLES SCHOOL WHITTIER

PROJECT LOCATOR BY VOLUNTEER ACTIVITY
SUB-CATEGORY CODE 113

EMPHASIS CODE	REGION	STATE	PROJECT NAME CITY
2	01	CT	S CENTRAL CONN FOSTER GRANDPARENT PROGRAM W HAVEN
2	01	MA	URBAN LEAGUE OF SPRINGFIELD SPRINGFIELD
2	01	ME	PORTLAND FOSTER GRANDPARENT PROGRAM PORTLAND
2	01	NH	SOUTHWESTERN NH FOSTER GRANDPARENT PROGRAM GOFFSTOWN
2	02	NY	FEDERATION OF PARENTS ORGANIZATIONS FOR NYSMI INC BABYLON
2	03	OH	CLEVELAND F G P CLEVELAND
2	03	OH	DEPARTMENT OF YOUTH SERVICES FOSTER GRANDPARENTS COLUMBUS
2	03	PA	FOSTER GRANDPARENT PROGRAM EBENSBURG
2	03	PA	FGP ERIE
2	03	WV	WEST CENTRAL W V C A A INC F G P PARKERSBURG
2	04	FL	FOSTER GRANDPARENT PROGRAM OF JACKSONVILLE JACKSONVILLE
2	05	MI	BRANCH CALHOUN FOSTER GRANDPARENT PROGRAM COLDWATER
2	05	MI	MENOMINEE-DELTA-SCHOOLCRAFT HUMAN RESOURCES AUTHOR ESCANABA
2	05	MI	BERRIEN COUNTY FGP ST JOSEPH
2	06	LA	FOSTER GRANDPARENT PROGRAM BATON ROUGE
2	06	LA	FOSTER GRANDPARENT PROGRAM HAMMOND
2	06	MO	ST LOUIS FOSTER GRANDPARENT PROGRAM ST LOUIS

PROJECT LOCATOR BY VOLUNTEER ACTIVITY
SUB-CATEGORY CODE 113

EMPHASIS CODE	REGION	STATE	PROJECT NAME CITY
2	09	CA	SACRAMENTO FGP SACRAMENTO
2	09	CA	YOUTHFUL OFFENDER FGP SOQUEL
2	10	WA	FOSTER GRANDPARENT PROGRAM NESPELEM

QUESTION # 1

YOUNG VOLUNTEERS IN ACTION

YVA can been seen in many ways as a strong prevention program, giving young people a positive alternative to drug abuse and other negatives behaviors.

YVA projects are still very new and as such cannot be fully evaluated for their involvement in drug prevention.

QUESTION 2

The Federal Strategy Document for 1982 estimated that ACTION would spend $4.7 million on drug prevention programs in FY 1983. In your testimony before the Committee you said ACTION expenditures for 1983 were close to $7 million. Please provide the Committee with an analysis of ACTION support for drug prevention programs in 1983 by major funding category (e.g. demonstration grants, VISTA volunteers, Foster Grandparents, YVA's, etc.) For each major category, provide the total amount authorized, obligated and expended and state the number of projects and/or ACTION volunteers supported. Please provide similar estimates for fiscal years 1982 and 1984.

	1982	1983	1984
PART C DRUG GRANTS	$ 389,540	$ 563,263	$ 575,000
PART B DRUG GRANTS	$	$ 15,438	$ 15,438
SUPPORT	$ 140,000	$ 156,300	$ 121,000
VISTA	$ 2,408,000	$ 1,575,000	$ 1,575,000
SCP	$ 1,416,000	$ 1,864,000	$ 1,884,000
FGP	$ 2,238,000	$ 2,424,000	$ 2,112,000
RSVP	$ 195,412	$ 326,046	$ 523,026
TOTAL	$ 6,831,952	$ 6,924,047	$ 6,805,464

FY 1982

Part C Drug Grants	$389, 540
Part B Drug Grants	
Support	$140,000

VISTA (344 VSY) @ $7000	$2,408,000
SCP (472 VSY) @ $3000	$1,416,000
FGP (746 VSY) @ $3000	$2,283,000
RSVP (1994 Vols) @ 200 hrs. x .49 per hr.	$ 195,412
	$6,831,952

FY 1983

Part C Drug Grants	$ 563,263
Part B Drug Grants	$ 15,438
Support	$156,300

VISTA (225 VSY) @ $7000	$1,575,000
SCP (588 VSY) @ $3000	$1,864,000
FGP (808 VSY) @ $3000	$2,424,000
RSVP (3,327 Vols) @ 200 hrs x .49 per hr.	$ 326,046
	$6,920,617

FY 1984

Part C Drug Grants	$575,000
Part B Drug Grants	$ 15,438
Support	$121,000

VISTA (225 VSY) @ $7000	$1,575,000
SCP (628 VSY) @ $3000	$1,884,000
FGP (704 VSY) @ $3000	$2,112,000
RSVP (5,337 VOLS) @ 200 hrs. x $.49	$ 523,026
	$6,805,464

QUESTION 3

As we understand it, the purpose of your drug demonstration grants is to provide seed money to establish a self-sustaining, statewide parent organization in each state to promote and coordinate voluntary drug perevention efforts.

A. Is our understanding of the purpose of these grants correct?

Partly. We have three types of grants in the drug Prevention Program. The first is issued to organizations which provide information to volunteer groups throughout the country (PRIDE, Families in Action.) The second entails one-year, seed money grants to established state-wide networks of parents, enabling them to garner the stability and credibility they need to be self-sustaining. The third is the DARE programs, demonstrating the impact of volunteers on a more local level with a broad approach to adolescent drug use

B. How many of these organizations have you established so far and in which states?

Thus far we have awarded networking grants in 12 states: California, Oregon, New Mexico, Nebraska, Missouri, Indiana, Ohio, Kentucky, Tennessee, Florida, North Carolina, and New Hampshire. In addition, substantial field staff time has been devoted to prevention activities in Colorado, Iowa, and Alabama, along with limited material support. Also, we partially fund two D.A.R.E. projects, in the New York City area and Miami.

C. How long will you support these grantees (e.g. 1 year, 2 years?)

Our statewide networking grants are issued for one year. The D.A.R.E. grants and the national information grants have the possibility of being renewed yearly, still with the condition that they move toward self-sufficiency. Beyond grant monies, we make other ACTION resources (VISTA, etc.) known to our grantees.

D. Have any of these grantees become self-sustaining or is it too early to determine this?

With nearly all of our grantees it is too early to tell. However, states such as Kentucky and Florida have shown self-sufficiency already.

E. What criteria do you use in awarding these grants? How much consideration is given to whether the grantee will be able to meet the needs of low income individuals and communities, a traditional concern of other ACTION programs?

Grants to statewide networking organisations are judged using several criteria, including:

- Their ability to develop and expand a network of parent groups and other groups dedicated to the prevention of drug use by youth.

- The amount of broad-based community support they have and will be able to obtain.

- The applicability of their budget and objectives to their goals.

- Their ability to develop an approach to drug use prevention which clearly demonstrates the effectiveness of volunteers in drug prevention.

- The need in their state.

All of the state grantees in the ACTION Drug Prevention Program are seeking ways to reach and support low income groups and individuals. In the case of conferences, for example, many of the sponsoring organizations have offered scholarships for those unable to afford lodging, fees, and/or other expenses. 32% of Operation PAR's grant from ACTION was spent on scholarships. All state conferences charge minimal registration fees, averaging $5.00 for two to three day events.

D.A.R.E. programs are very much involved in assisting low income youth and families, and PRIDE, with its toll-free number and free packets of material, is also helping to meet the needs of those who lack resources and need assistance.

F. Are these grants awarded on a competitive basis?

No, not in the formal sense of the word "competitive."

If not, do you have any plans to adopt competitive procedures in awarding these grants?

The amount of money involved in the demonstration component of the Drug Prevention Program is relatively small. Therefore, a Request for Grant Applications would not be advantageous to either ACTION or potential applicants.

G. How do you plan to evaluate these grants to determine if they are successful? When will your evaluations be available?

We are constantly reviewing the ability of these grantees to become self-sufficient and expansive. We began with and still adhere to the belief that organized volunteers, both parents and youth, on a grassroots level, have the best chance of reducing the use of drugs on a large scale in this country. For further documentation of this fact, PRIDE is currently working with N.I.D.A. in the hope of developing and implementing an evaluation tool which can gauge the success of parent groups and other volunteer community groups working toward drug use prevention. On a purely financial basis, ACTION does hold random audits and some of the drug grants have been among those audited. In addition, the Pharmacists Against Drug Abuse program was evaluated by ACTION's Evaluation Division, an independent section of the agency.

H. Section 403(b) of the Domestic Volunteer Service Act prohibits programs assisted by ACTION from using ACTION funds to lobby for the passage or defeat if legislation. Since parent groups have frequently been actively involved in lobbying activities--sometimes quite effectively--what steps is ACTION taking to assure that ACTION demonstration grant funds will not be used for prohibited political activities?

Our General Counsel reviews all grant applications to ensure no violation of 403(b) exists within the applications itself. When the grant is awarded, all recipients receive a copy of the regulation and the matter is thoroughly discussed. It is very clear that our monies are intended and used for purposes other than those prohibited by 403(b).

QUESTION # 4

How does ACTION coordinate its activities with NIDA to assure there is no duplication of effort?

ACTION, since the outset of the Drug Prevention Program, has kept in close communication with a number of NIDA officials and on many occasions. ACTION sits on several inter-agency task forces and committees with NIDA and others. We have combined our efforts with NIDA several times. For example, NIDA and ACTION provided materials and technical assistance to the General Federation of Women's Clubs and their new drug prevention program.

5a Does NIDA review public information materials prepared by ACTION prior to their publication and dissemination to assure that they are consistent with NIDA's research findings and also that they do not duplicate materials already available through the Nation Clearinghouse for Drug Abuse Information?

The White House Office of Drug Abuse Policy has replaced NIDA as the authority to review drug-related materials from the various agencies and departments.

5. b. Did NIDA review, prior to publication, the pamphlets prepared for ACTION by the American Council for Drug Education? What steps did ACTION take to determine whether suitable materials were already available through NIDA before awarding grants to the American Council for Drug Education for the pamphlets?

NIDA did not review the CDE brochures prior to their publication. ACTION was aware that the Scientific Advisory Board of CDE was composed of researchers who are active in the field, are grantees of NIDA conducting research in this area, or are former employees of NIDA. In addition, the president of CDE is the former director of NIDA.

ACTION reviewed materials made available to it by the staff of NIDA. We found that the brochures which CDE proposed to produce for ACTION in no way duplicated those produced by NIDA and made available to parents upon request.

Other pamphlets produced by ACTION have made extensive use of information from NIDA publications, specifically the High School and Household Surveys on drug use. In addition, statements regarding the chemical composition of marijuana have been taken from NIDA materials. These other publications deal specifically with the role of volunteers and are not applicable to NIDA.

QUESTION # 4 (5)
page 2

5c We understand that the American Council for Drug Education retains the right to sell to the public the pamphlets it prepared under grants from ACTION. Is it customary and appropriate for the Government to give a private grantee such as the Council the right to sell public information materials developed with public funds?

U.S. Code 17§105 gives a federal agency the right to determine whether or not a grantee may retain the copyright to the material it produces with federal monies. At the same time, ACTION has the right to produce unlimited quantities of such material. ACTION reviewed the Code and decided to allow CDE to retain its copyright since ACTION only funded the condensation of the CDE monographs and not the research itself or the published findings.

QUESTION # 6

What is ACTION doing to assure that the volunteer efforts it is promoting will be coordinated with the efforts of drug treatment and prevention professionals in states and local communities?

From the outset, the Drug Prevention Program has been in close communication with NASADAD (the National Association of State Alcohol and Drug Abuse Directors) and has kept them updated on our activities. In the spring of 1983, ACTION field staff collected information on the status of drug abuse, and prevention, in every state. In order to obtain this information, our state directors were in close contact with Single State Agencies and have maintained those contacts since. The Chemical People program, in the fall of 1983, brought another opportunity for cooperation. In Colorado, for example, ACTION's Regional Director chaired the Chemical People Committee and worked very closely with the Prevention Coordinator for the State Alcohol and Drug Abuse Division of the State Department of Health.

All of our state grantees have close working relationships with professionals in their states. Among the criteria we use in the selection of grantees is their ability to build coalitions, and the amount of broad-based support they have garnered. In Oregon, for example, our grantee received substantial assistance from the Single State Agency Director throughout their formation. In Florida, the Single State Agency is strongly supportive of Florida Informed Parents and Operation PAR. The Alabama Department of Mental Health is the recipient of over 30 VISTA's, who are forming predominantly low-income parent groups. Without exception, this kind of cooperation is evident in all of the states to which we have given grants.

How would you characterize ACTION's relationship with state and local drug abuse agencies?

Cooperative, constantly growing and positive.

QUESTION # 7

On page 5 of your testimony, you discuss the Pharmacists Against Drug Abuse Program. Would you please provide to the Committee ACTION's evaluation of the P.A.D.A. materials and the results of the five surveys McNeil Pharmaceutical has conducted evaluating the program?

They are enclosed.

Has any independent evaluation of the program been conducted or is any such evaluation planned?

The evaluation conducted by ACTION's Evaluation Division is considered to be an independent effort because it is seperate from any program office in the agency. It should also be noted that to hire an outside contractor to evaluate a program of such limited funding would not be cost effective.

DRUG USE PREVENTION INFORMATION DISSEMINATION MARKETING SURVEY

INDICATIONS FROM THE MARKETING SURVEY DATA

ACTION

March 1983

TABLE OF CONTENTS

Foreword. i
Summary ii
Introduction 1
Information on Data Collection Sites 4
Demographic Characteristics of Respondents 9
Effectiveness of the Brochure. 12
Conclusions. 16
Attachments. 17
  Attachment A: Store Data Instrument
  Attachment B: On-site Interview Instrument
  Attachment C: Consent Form
  Attachment D: Thank You Letter
  Attachment E: Follow-up Telephone Survey Instrument

LIST OF TABLES

Table 1: Data Collection Sites 2

Table 2: Store Characteristics 4

Table 3: Marketing of Brochure by Pharmacist 5

Table 4: Pharmacist Enthusiasm and Overt Support 6

Table 5: Average Number of Interviews per Day per Store . 6

Table 6: Average Number of Brochures Distributed per Day per Store. 7

Table 7: Demographic Characteristics of Respondents. . . . 9

Table 8: Comments by Respondents 15

DRUG USE PREVENTION INFORMATION DISSEMINATION

MARKETING SURVEY

FOREWORD

McNeil Pharmaceutical in conjunction with ACTION has mounted and conducted an information dissemination campaign on drug use prevention. The program included the writing, release, and pilot testing of a brochure which was to describe the harmfulness of drug use and was to be distributed through local participating drug stores. The brochure was to be written to attract the attention of two population groups: parents with young children and other concerned individuals.

A general marketing survey was requested by McNeil Pharmaceutical. The survey was meant to gather perceptions by the public on the usefulness of the information in the brochure and some general demographic information about the respondents. No rigorous scientific method with comparison or control groups was used. This statement of indications from the survey data has been prepared for ACTION's internal use in deciding whether and how the brochure should be changed for use in a subsequent nationwide campaign.

DRUG USE PREVENTION INFORMATION DISSEMINATION

MARKETING SURVEY

SUMMARY

A focused marketing survey was conducted as part of the pilot project of the Pharmacists Against Drug Abuse Program (PADA). PADA was established as a cooperative effort of the ACTION Drug Prevention Program and McNeil Pharmaceutical. The Drug Prevention Program within ACTION was established in 1981 and supports President and Mrs. Reagan's commitment to a drug free society.

McNeil Pharmaceutical agreed to reproduce and distribute to pharmacists the following materials:

- a brochure covering the health consequences of marijuana, alcohol, and PCP for distribution to the public;
- a pharmacists manual covering in detail a variety of illicit drugs and encouraging the pharmacist to become a resource to the community;
- a poster for each pharmacist's window advertising the availability of the free materials;
- camera-ready advertisement sheets for the pharmacists to insert in local newspapers; and
- public service announcements using celebrities.

The brochure, "The Kinds of Drugs Kids Are Getting Into", was produced by the American Council on Marijuana through a grant from ACTION.

A pilot project of the Pharmacists Against Drug Abuse was launched on November 15, 1982 in Maine, Massachusetts, and New Hampshire. The marketing survey was conducted November 16 through 20 in 26 local drug stores to test the usefulness of the information in the brochure as perceived by those who took the brochure and read it. McNeil Pharmaceutical requested ACTION to conduct the survey.

Data Collection and Analysis

Data Collection took place in two parts: on-site data collection in November 1982 and telephone follow-up data collection in January and February 1983. Twenty-six stores were randomly selected from a list of stores recommended by McNeil Pharmaceutical as having a customer traffic flow considered necessary for such market survey efforts. Three of the original 26 stores withdrew from the survey after data collection had begun and three replacement stores were added so a total of 29 stores were involved in the survey although no more than 26 stores were used as data collection sites on any one day. Information was collected on the data collection sites using the Store Data Instrument (one for each store).

Individuals picking up the brochures in the stores were approached and, if willing, interviewed using the On-site Interview Instrument. Of the 878 persons interviewed on site, 765 consented to follow-up telephone interviews. A random selection of two hundred and eighty-eight persons of the 765 were interviewed using the Follow-up Telephone Survey Instrument. Numerous descriptive statistics and crosstabulations were conducted for selected variables both across and within the three instruments to prepare this statement on indications suggested by the survey results.

Indications

The information gathered and the observations of data collectors indicate that the brochure has been favorably received.

- Eighty-seven percent (87%) of those who were interviewed on site read the brochure.
- Eighty-five percent (85%) of those who read the brochure thought that they would feel comfortable sharing information from the brochure with a drug abuser.
- Eighty percent (80%) of those who read the brochure felt that its publication and distribution is an effective way of fighting drug abuse.
- Forty-five percent (45%) of the respondents, who were not currently involved with volunteer groups that can use this kind of information, thought that they would do volunteer work in the community in the area of drug abuse prevention after having read the brochure. Twenty-two percent (22%) of the respondents were already involved with volunteer groups that can use this kind of information; however, 72% of this group of respondents had not yet used the information within their volunteer activity at the time of the telephone follow-up survey.

Many of the suggested improvements to the brochure indicate that some respondents may have forgotten or not understood the primary purpose of the brochure, i.e., to help parents and youth become aware of the drug problem and to provide resources for drug abuse prevention. Also, about half of those attracted to the brochure and interviewed on site were of the age group most likely to have young children; 21% were 11 to 21 years of age.

The "typical" person interviewed after picking up a brochure was a White female 22 to 45 years of age.

- Eighty-four percent (84%) of those interviewed were White.
- Sixty-one percent (61%) of those interviewed were female.
- Fifty-one percent (51%) of those interviewed were 22 to 45 years of age.

The "typical" store selected for on-site data collection was an independent proprietorship serving a White, rural area.

- Ninety-three percent (93%) served White areas.
- Seventy percent (70%) were independent proprietorships.
- Forty-one percent (41%) served rural areas.

DRUG USE PREVENTION INFORMATION DISSEMINATION MARKETING SURVEY

INTRODUCTION

ACTION's Drug Prevention Program (ADPP)

The ACTION Drug Prevention Program, which supports President Ronald Reagan's and Mrs. Reagan's commitment to a drug free society, was established in 1981. The aim of the program is to mobilize volunteers from all segments of the community--parents, teachers, children, and business groups--to get involved in the prevention of drug abuse among adolescents. Besides providing technical assistance and grants, other ACTION programs such as the Young Volunteers in ACTION (YVA) and the Retired Senior Volunteer Program (RSVP) play a very vital role in the Drug Prevention Program. Past major activities have included the appointment of actress Melissa Gilbert as national spokesperson for the program and sponsorship of the White House Briefing on Drug Use and the Family hosted by Nancy Reagan.

Pharmacists Against Drug Abuse

A major new activity of the Drug Prevention Program is the Pharmacists Against Drug Abuse Program (PADA). The PADA program is a joint effort of ACTION and McNeil Pharmaceutical. McNeil Pharmaceutical has agreed to reproduce and distribute to pharmacies the following materials: a brochure covering the health consequences of marijuana, alcohol, cocaine, and PCP for distribution to the public; a pharmacist's manual covering in detail a variety of illicit drugs and encouraging the pharmacist to become a resource to the community; a poster for each pharmacist's window advertising the availability of the free materials; camera-ready advertisement sheets for the pharmacists to insert in local newspapers; and public service announcements using celebrities. The brochure, "The Kinds of Drugs Kids Are Getting Into", was produced under a grant from ACTION by the American Council on Marijuana and was submitted for editorial comment to several volunteer and professional groups.

On November 15, 1982, a pilot project of the Pharmacists Against Drug Abuse program was launched in Maine, Massachusetts, and New Hampshire to test the materials and the procedures. ACTION was requested to do and did a marketing survey of the pilot project. It is intended that PADA become nation-wide in May 1983.

Data Collection and Analysis

From a list of pharmacies and drug stores furnished to ACTION by McNeil Pharmaceutical, 26 sites were randomly selected for on-site data collection (See Table 1). All of

TABLE 1
DATA COLLECTION SITES (1)

Store Name	City and State
The Medicine Shoppe	Norway, ME
Holland's Variety Drug Store	Skowhegan, ME
Wilson's Drug Store	Bath, ME
Wellby Super Drug Store	Biddeford, ME
Liggett Rexall Drug Co.	Bangor, ME
Rosemont Pharmacy Inc.	Portland, ME
Plaza Pharmacy, Inc.	Houlton, ME
Yarmouth Pharmacy	Yarmouth, ME
Ohnart & Hinkley Druggists	Hampden, ME
Wellby Super Drug Store	S. Portland, ME
Drapeau's Pharmacy, Inc.	Brunswick, ME
Wellby Super Drug Store	Bangor, ME
Concord Apothecary Shop Inc. (2)	Concord, MA
Beatty Brothers Pharmacy	Waltham, MA
Fields Corner Pharmacy Inc.	Dorchester, MA
Jefferson Drug Co., Inc.	Peabody, MA
Lang and Moore Drug Inc.	Dorchester, MA
Pawtucket Pharmacy of Lowell Inc. (3)	Lowell, MA
Tremont Drug (4)	Boston, MA
Brattle Pharmacy, Inc.	Arlington, MA
Towne Plaza Drug Inc. (5)	Billerica, MA
Pages Drug Store	Chelmsford, MA
Berlin Drug Co.	Berlin, NH
Plymouth Pharmacy	Plymouth, NH
Scott Pharmacy	Wolfeboro, NH
Metz Drug Co. (6)	Manchester, NH
Lakeport Rexall Drug Store (7)	Lakeport, NH
Crawford Drug Store (8)	Dorchester, MA
Prudential Center Pharmacy (8)	Boston, MA

---

(1) Sites are listed in the order that they were randomly selected.
(2) Withdrawn from participation in data collection at the pharmacist's request before data collection began.
(3) Data collection did not take place on day 4.
(4) Data collection took place on day 1 only, survey was discontinued at the pharmacist's request due to limited space.
(5) Data collection did not take place on day 5.
(6) Data collection took place on day 1 only, survey was discontinued at the pharmacist's request.
(7) This is a replacement store, data collection took place on days 3 and 4 only.
(8) This is a replacement store, data collection took place on days 3, 4, and 5 only.

the stores recommended met a level of consumer traffic flow deemed necessary for marketing surveys. Three of the original 26 stores withdrew from participation in on-site data collection after data collection had begun and three replacement stores were added so that a total of 29 stores were involved. Data was actually collected at 28 sites although not at more than 26 on any one day. A Store Data Instrument was completed for each store (See Attachment A).

The PADA pilot project was kicked-off on Monday, November 15, 1982. On-site data collection*, with one data collector at each store, began on Tuesday, November 16 and lasted through Saturday the 20th. Each data collector would approach each person who picked up a brochure and request an interview using the On-site Interview Instrument (Attachment B). Persons picking up brochures while the data collector was engaged in an interview were not interviewed. All interviews and responses were voluntary. Each respondent signed a consent form (Attachment C) before the interview and received a letter thanking him/her for his/her participation and explaining his/her rights under the Privacy Act (Attachment D). Eight hundred and seventy-eight persons were interviewed.

Of those interviewed on site, 721 consented to a telephone follow-up interview and 44 requested a follow-up by mail, i.e., 87% of those who were interviewed consented to a follow-up interview. Of the 35 data collectors engaged in this activity, 16 were assigned to ACTION headquarters in Washington, DC and 19 to the ACTION Region I Office which is headquartered in Boston, MA.

Of the 765 persons who consented to follow-up interviews, 398 were randomly selected for follow-up interviews. Data collection was conducted from January 20 through February 3, 1983 using the Follow-up Telephone Survey Instrument (Attachment E). All calls were made from ACTION headquarters in Washington. Twenty-nine persons were mailed instruments at their request, 81 respondents were not reached due to disconnected phones, etc., and 288 telephone interviews were completed. To date, seven of the 29 mailed-out instruments have been completed and returned and two have been returned undeliverable.

Data Analysis

The Drug Use Prevention Information Dissemination Marketing Survey involved data collection from three instruments: Store Data Instrument, On-site Interview Instrument, and Follow-up Telephone Survey Instrument. Numerous descriptive statistics and crosstabulations were conducted for selected variables both across and within the three instruments.

---

* Data collection was approved by the Office of Management and Budget on November 12, 1982 (OMB #3001-0080).

DRUG USE PREVENTION INFORMATION DISSEMINATION MARKETING SURVEY

INFORMATION ON DATA COLLECTION SITES

Purpose

This section provides information on the data collection sites used for this marketing survey.

Data Collection Sites

Twenty-six pharmacies and drug stores (stores) were randomly selected from a list of 123 stores recommended by McNeil Pharmaceutical from more than a thousand stores in the three-state area (See Table 1). The recommendation was based on the stores having a customer traffic flow considered necessary for such marketing survey efforts. Twelve stores were in Maine, ten in Massachusetts, and four in New Hampshire. The 12:10:4 ratio is the same ratio as that of the number of stores recommended in each state by McNeil Pharmaceutical.

TABLE 2
STORE CHARACTERISTICS

(Source: Store Data Instrument)

Characteristic	Number of Responses	Percent
Type of Ownership	(N=27)	
Independent proprietor	19	70
National chain	2	7
Major chain (6 or more stores)	1	4
Small chain (2-5 stores)	5	19
Location	(N=27)	
Urban	7	26
Suburban	9	33
Rural	11	41
Ethnic Area	(N=28)	
American Indian	0	0
Asian	0	0
Black	1	4
Hispanic	1	4
White	26	93

According to the data collected using the Store Data Instrument (Attachment A):

- 93% of the randomly selected stores serve non-minority areas (See Table 2);
- 70% of the stores were independent proprietorships;
- 44% of the stores serving non-minority areas were in rural areas;
- 41% of all stores were in rural areas; and
- minority area stores (7% of total stores) were in urban areas and were independent proprietorships.

Marketing of the Brochure

Each pharmacist was responsible for the distribution and promotion of the brochure in his/her store.

TABLE 3
MARKETING OF BROCHURE BY PHARMACIST

(Source: Store Data Instrument)

Category	Number	Percent
Location of Brochure in Store	(N=42)*	
Drug counter	21	75
Front of store check-out	9	33
Front of store not at check-out	5	19
Information rack	3	11
Other location	4	15
Wearing of Project ID by Pharmacist	(N=28)	
Worn	6	21
Not worn	22	79
Advertising Done by Store	(N=26)*	
None	11	39
City newspaper	0	0
Local newspaper	1	4
Flyers	3	11
Radio	2	7
TV	1	4
Other	8†	30

* Some stores used more than one method.
† Includes displaying of poster (7 cases).

As indicated by Table 3, the drug counter was the principal location in the store for distributing the brochure. Advertising by the pharmacists was minimal, there were only four instances of the use of radio, TV, or newspaper. In only six of the 28 stores did a pharmacist use the breast pocket, pencil holder bearing the PADA symbol and "Ask me about Drug Abuse".

Pharmacist Enthusiasm

Data collectors were asked, based on their own observations, to rate the overall enthusiasm and overt support of the pharmacist towards the program. About 79% of the pharmacists were rated as having a good to excellent attitude (See Table 4).

TABLE 4
PHARMACIST ENTHUSIASM AND OVERT SUPPORT

(Source: Store Data Instrument)

Rating	Number of Pharmacists	Percent
Excellent	10	36
Good	12	43
Fair	5	18
Poor	1	4
	(N=28)	

Volume of Interviews

From November 15 through November 20, 1982, 878 persons were interviewed at the 28 stores. The average number of persons interviewed in each store during the five-day period was 31 with a range of 0-97 (See Table 5).

TABLE 5
AVERAGE NUMBER OF INTERVIEWS PER DAY PER STORE

(Source: Store Data Instrument)

Day	Average	Range	
1	7	0 - 24	(N=25)*
2	7	0 - 16	(N=23)
3	8	0 - 25	(N=26)
4	7	0 - 17	(N=25)
5	6	0 - 22	(N=24)
Total	31	0 - 97	(N=28)

---

*Data collection did not take place at all stores on each day.

The relationship between the pharmacist's enthusiasm and the total number of interviews at the store was determined to be as follows:

- 80% of the stores in which the pharmacist showed fair enthusiasm had less than 20 total interviews.
- 42% of the stores in which the pharmacist showed good enthusiasm had less than 20 total interviews.
- Only 10% of the stores in which the pharmacist showed excellent enthusiasm had less than 20 total interviews.

This suggests that the pharmacist's enthusiastic and overt support of the project influenced the success of the data collection process.

In relation to the type of area (urban/suburban/rural) served by the stores, the data indicates that:

- 64% of the rural stores had less than 20 interviews;
- 43% of the urban stores had 40+ interviews; and
- 33% of the suburban stores had 40+ interviews.

Volume of Brochures Distributed

During the data collection period, 1,398 brochures were distributed at the 28 stores. The average number of brochures distributed in each store during the five-day period was 50 with a range of 10 to 176 (See Table 6).

TABLE 6
AVERAGE NUMBER OF BROCHURES DISTRIBUTED
PER DAY PER STORE

(Source: Store Data Instrument)

Day	Average	Range	
1	15	0 - 62	(N=25)*
2	10	0 - 24	(N=23)
3	13	1 - 46	(N=26)
4	12	1 - 42	(N=25)
5	11	10 -176	(N=28)

---

*Data collection did not take place at all stores on each day.

The average number of brochures distributed per day per store was more variable than was the average number of interviews per day per store. The highest average number of interviews was on the third day; the highest average number of brochures distributed was on the first day.

DRUG USE PREVENTION INFORMATION DISSEMINATION MARKETING SURVEY

DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

Purpose

This section provides demographic data on the 878 persons (respondents) who were interviewed on site from November 16 through 20, 1982 (See Table 7). On-site data collection took place at 28 pharmacies or drug stores (stores) in Maine, Massachusetts, and New Hampshire. Since the 22 to 45 year old age group is the age group most likely to have children needing drug abuse prevention information, special emphasis is being given to age in analyzing respondent demographics.

TABLE 7
DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

(Source: On-site Interview Instruments)

Characteristic	Percent	Characteristic	Percent
Sex	(N=866)	Age	(N=871)
Female	61	10 or younger	*
Male	39	11-15	6
		16-21	15
		22-45	51
Ethnic Background	(N=859)	46-59	15
American Indian	1	60 and older	12
Asian	1		
Black	13		
Hispanic	2	Occupation	(N=878)
White	84	Professional	21
		Clerical & sales	15
		Service	10
		Agriculture	1
Sex and Ethnic Background	(N=859)	Processing	2
White male	32	Machine trades	3
White female	51	Benchwork	*
Nonwhite male	7	Structural work	2
Nonwhite female	9	Housewife	16
		Unemployed	4
		Pupil/student	15
		Other†	12
		No response	1

---

* Less than one percent
† Includes retired

Age Groups

About half of the persons interviewed on-site were from 22 through 45 years of age, which is the age group most likely to have young children. Of those interviewed in this age group:

- 84% were White;
- 61% were female;
- 42% were interviewed in suburban stores;
- 30% had professional, technical, and managerial occupations;
- 29% were interviewed in rural stores;
- 29% were interviewed in urban stores:
- 18% had clerical and sales occupations; and
- 14% were Black.

Fifteen percent (15%) were in the 46 to 59 age group which could also have young children. Of this age group:

- 93% were White;
- 68% were female;
- 28% had professional, technical, and managerial occupations;
- 13% had clerical and sales occupations; and
- 5% were Black.

Age and Area

These statistics indicate that the respondents interviewed in suburban and rural area stores represent an older subpopulation than those interviewed in urban area stores.

- 36% of those interviewed in rural areas were over 45 years of age.
- 32% of those interviewed in suburban areas were over 45 years of age.
- 13% of those interviewed in urban areas were over 45 years of age.

Age and Ethnic Group

The following statistics demonstrate that those interviewed in White areas represent an older population than those interviewed in nonwhite areas.

- 20% of those interviewed in White areas were over 45 years of age.
- 6% of those interviewed in Black areas were over 45 years of age.

DRUG USE PREVENTION INFORMATION DISSEMINATION MARKETING SURVEY

EFFECTIVENESS OF THE BROCHURE

Purpose

This section summarizes statistics related to the perceived effectiveness of the brochure and the question of whether or not the brochure, "The Kinds of Drugs Kids Are Getting Into", should be changed prior to further distribution. The information was collected during 878 on-site interviews in November 1982 and 288 telephone follow-up interviews in January and February 1983. On-site data collection took place at 28 sites in Maine, Massachusetts, and New Hampshire.

Audience

Of those interviewed on-site, 51% were 22 to 45 years of age, the age group most likely to have young children needing drug abuse prevention information. Of the remaining 49%, 22% were 21 years of age or younger and 27% were 46 or older.

Acceptance of the Brochure

The following statistics indicate a generally favorable acceptance of the brochure as determined by the telephone follow-up survey.

- Of those interviewed, 87% had read the brochure.
- Of those who read the brochure, 80% said they would have read the brochure even if they had not been expecting a follow-up interview.
- Of those who read the brochure, 80% felt that its publication and distribution is an effective way of fighting drug abuse. Of those who thought that they would do volunteer work in the community, 86% thought that the brochure was an effective way of fighting drug abuse.

Effectiveness of Content

The following statistics indicate that the brochure's content had a favorable influence on those who read it.

- 85% thought that they would feel comfortable sharing information from the brochure with a drug abuser.
- 78% would consult their pharmacist about drug abuse information.

- 70% now feel more comfortable and prepared to discuss the prevention of illegal drug use.

- 70% would consult the other resources listed at the end of the brochure (only 2% had actually done so).

- 53% thought that they would be able to recognize a drug user based on the material in the brochure.

- 47% of those who thought the brochure was effective used it in their families. Moreover, 54% of those who were 22 to 45 years of age and who thought that the brochure was effective had used it in their families.

- 28% of those who thought the brochure was effective used it in social groups (which included both formal and informal groups); 26% of those who were 22 to 45 years of age and who thought the brochure was effective used it in social groups. Some respondents who used the brochure used it in more than one way.

- 40% said that they learned something about drug abuse prevention that they did not already know.

Effect on Voluntarism

These statistics indicate the extent of the effect of the brochure on voluntarism.

- 50% of those who feel more comfortable and prepared to discuss the prevention of illegal drug use thought that they would do volunteer work in the community.

- 47% of those who learned something about drug abuse prevention from the brochure thought that they would do volunteer work in the future.

- 46% of those who thought the brochure was effective, thought that they would do volunteer work.

- 45% of the respondents, who were not currently involved with volunteer groups that can use this kind of information, thought that they would do volunteer work in the community in the area of drug abuse prevention after having read the brochure. Twenty-two percent (22%) of the respondents were already involved with volunteer groups that can use this kind of information; however, 72% of this group of respondents had not yet used the information within their volunteer activity at the time of the telephone follow-up survey.

- 24% of the pharmacists plan to volunteer to become a general community resource (Source: Store Data Instrument.

Other Drugs

Most people were satisfied with the information in the brochure. Thirty-one percent (31%), however, said that there were other drugs not mentioned in the brochure about which they would like to know more (Question 10, Follow-up Telephone Survey). Drugs that this group of respondents wanted to know about included:

- "uppers and downers" (31%);
- wrongfully used prescription drugs (18%);
- wrongfully used non-prescription drugs (16%);
- LSD (15%);
- heroin (11%);
- angel dust (9%); and
- various miscellaneous responses (34%).

Some respondents wanted additional information on more than one drug. It is not clear whether the respondents wanted more information about angel dust or they had forgotten that it had been included in the brochure.

Forty-eight percent (48%) of the respondents who felt that the publication and distribution of the brochure was an effective way of fighting drug abuse also said that there were other drugs not mentioned in the brochure about which they would like to know more.

Thirty percent (30%) of those who said that they did not learn something about drug abuse prevention from the brochure and 37% of those who used the brochure with their families wanted to know more about other drugs.

Comments by Respondents

The responses to the question "Is there anything else about the brochure or drug abuse prevention you would like to add to what we have just discussed? If yes, what?" have been divided into five types of comments (See Table 8).

TABLE 8
COMMENTS BY RESPONDENTS

(Source: Question 17, Follow-up Telephone Survey)

Category	Number of Responses	Percent
Type of Comment	(N=106)	
Positive	33	31
Suggestion*	30	28
Other	22	21
Distribution†	15	14
Negative	6	6
*Suggestion	(N=30)	
More detail	15	50
Other	5	17
State stronger	4	13
Local phone number	3	10
Other target population	3	10
†Distribution	(N=15)	
School	6	40
Other	4	27
Library	2	13
Mail	2	13
Grocery	1	7

Table 8 shows that only 6% of the responses were of a totally negative nature. Most of the "other" comments did not deal directly with the brochure itself.

The brochure was intended to provide concise and sound information using layman's language and a format that was eye-catching and easy to read in order to increase awareness of the results of drug abuse and to increase the involvement of parents in drug use prevention. A review of the comments indicates that a few respondents apparently overlooked the fact that the brochure was aimed at that portion of the total population which was parents of young children. Although the purpose of the brochure is given at the end of the first section and featured on the back, neither the title nor the front page state that it is a resource brochure for parents.

The comments on the distribution of the brochure have been handled separately because they deal more with the marketing of the brochure than with its content; however, they do suggest ways in which the brochure might be made available to more parents of young children.

DRUG USE PREVENTION INFORMATION DISSEMINATION MARKETING SURVEY

CONCLUSIONS

The Data Collection Sites

The "typical" store selected for on-site data collection (considering the variables of ownership, ethnic area, and urban versus rural area) was an independent proprietorship serving a White, rural area. Sixty-three percent (63%) of the stores were independent proprietorships serving White areas; 30% were independent proprietorships serving White, rural areas. Little publicity was done by the pharmacists to promote the brochure; in fact, only 2% of the respondents came onto the stores specifically to get a copy of the brochure. Seventy-eight percent (78%) of the respondents first learned of the brochure when they saw it on display. Seventy-nine percent (79%) of the pharmacists were rated by the data collectors as having good to excellent attitudes towards the program. The average number of interviews per store per day was fairly consistent throughout the five days of data collection with the third day (Thursday) being the highest and the fifth day (Saturday) being the lowest. Those stores where the pharmacists' attitudes were rated higher tended to have more interviews. Several data collectors commented that according to their observations the pharmacists were extremely busy people with little time to spare for new projects.

The Respondents

The "typical" respondent (considering the variables of ethnic group, sex, and age group) was a White female 22 to 45 years of age. Fifty-one percent (51%) of all respondents were White females; 26% were White females 22 to 45 years of age. She most likely would have gotten the brochure at a rural or urban store and would not have gone to the store for the brochure but would have seen it there for the first time.

The Effectiveness of the Brochure

The information gathered and the observations of data collectors indicate that the brochure has been favorably received. Half of the people attracted to the brochure and interviewed on site were 22 to 45 years of age, the age group most likely to have young children. Of those that read the brochure, 80% felt that the publication and distribution of the brochure was an effective way of fighting drug abuse and 78% would consult their pharmacist about drug abuse information.

Attachment A

STORE DATA INSTRUMENT

DRUG PREVENTION INFORMATION DISSEMINATION EVALUATION

Store Data Instrument

NOTE: THIS INSTRUMENT MUST BE COMPLETED PRIOR TO THE COMPLETION OF THE INTERVIEWS AT THE PHARMACY/DRUG STORE. MOST OF THE ANSWERS ARE BASED ON THE INTERVIEWERS OBSERVATIONS IN THE STORE.

/__/__/ Interviewer code
CC 1-2

/__/__/ Store code for evaluation
CC 3-4

1. In what type of area is the store located?

☐ cc 5

1 Urban (the major city in a metropolitan area or a city or town which is not part of a metropolitan area but is a major city)

2 Suburban (a town or city within a metropolitan area but not the major city in the metropolitan area)

3 Rural (a town, a small city, or an unincorporated area not part of a metropolitan area)

2. What are the store's hours?

cc 6-9
cc 10-13

☐☐☐☐ to ☐☐☐☐ (24 hour clock)

3. What is the major ethnic make-up of the area where the store is located?

(NOTE: Code based on information provided by McNeil Pharmaceutical).

☐ cc 14

1 American Indian/Alaskan Native
2 Asian/Pacific Islander
3 Black (not of Hispanic origin)
4 Hispanic
5 White (not of Hispanic origin)

4. In which location in the store is the brochure distribution rack located?

(Code all 5 — Put "0" for NO; "1" for YES)

☐ cc 15 1 Drug counter

☐ cc 16 2 Front of store check-out

☐ cc 17 3 Front of store not at a check-out

☐ cc 18 4 At an information hand-out rack located elsewhere in the store.

☐ cc 19 5 Other location______________________________________

5. Did the pharmacist wear the project button?

☐ cc 20

0 No
1 Yes

6. What kind of advertising for the project did the store do, if any?

(Code all 6 — Put "0" for NO; "1" for YES)

☐ cc 21 0 None

☐ cc 22 1 Newspaper, city

☐ cc 23 2 Newspaper, local

☐ cc 24 3 Flyers

☐ cc 25 4 Radio

☐ cc 26 5 TV

☐ cc 27 6 Other ______________________________

7. How would you rate the overall demonstrated enthusiasm and overt support of the pharmacist toward the project?

☐ cc 28

1 Excellent
2 Good
3 Fair
4 Poor

(NOTE: Ask the pharmacist for the answers to questions 8, 9, and 10).

8. Which type of store is this?

☐ cc 29

1 Independent proprietor
2 National chain
3 Major chain (6 or more stores)
4 Small chain (2 - 5 stores)

9. How well did the pharmacist's handbook for the project meet the pharmacist's needs?

☐ cc 30

0 Handbook not received
1 Handbook received but not used
2 Provided proper kind and amount of information
3 Provided proper kind but not enough information
4 Did not provide needed information

10. As a result of this project, which of the following activities does the pharmacist plan to do?

☐ cc 31

1 Volunteer to become a general community resource
2 Become an information resource to his/her clientel only
3 Only disseminate materials
4 Other ____

11. How many brochures were distributed and how many persons were interviewed each day?

NOTE: RECORD AT THE END OF INTERVIEWING EACH DAY

Day 1

☐☐☐☐☐☐ cc 32 - 37 Date (month/day/year)

☐☐☐☐ cc 38 - 41 Brochures distributed*

☐☐☐ cc 42 - 44 Persons interviewed

☐☐☐ cc 45 - 47 Persons refusing interview

Day 2

☐☐☐☐☐☐ cc 48 - 53 Date

☐☐☐☐ cc 54 - 57 Brochures distributed*

☐☐☐ cc 58 - 60 Persons interviewed

☐☐☐ cc 61 - 63 Persons refusing inteview

---

*NOTE: Obtain information with the cooperation of the pharmacist. The number of brochures distributed is the number on display at the start of the day plus those added to the display during the day minus the number on display at the end of the day.

Day 3

☐☐☐☐☐☐ Date
cc 64 - 69

☐☐☐☐ Brochures distributed*
cc 70 - 73

☐☐☐ Persons interviewed
cc 77 - 76

☐☐☐ Persons refusing interview
cc 77 - 79

Day 4

☐☐☐☐☐☐ Date
cc 80 - 85

☐☐☐☐ Brochures distributed*
cc 86 - 89

☐☐☐ Persons interviewed
cc 90 - 92

☐☐☐ Persons refusing interview
cc 93 - 95

Day 5

☐☐☐☐☐☐ Date
cc 96 - 101

☐☐☐ Brochures distributed*
cc 102 - 104

☐☐☐ Persons interviewed
cc 105 - 107

☐☐☐ Persons refusing interview
cc 108 - 110

12. Total amounts for the five-day period

☐☐☐☐ Total brochures distributed
cc 111 - 114

☐☐☐☐ Total persons interviewed
cc 115 - 118

☐☐☐☐ Total persons refusing interview
cc 119 - 122

Attachment B

ON-SITE INTERVIEW INSTRUMENT

DRUG PREVENTION INFORMATION DISSEMINATION EVALUATION

On-site Interview Instrument

☐☐☐☐☐☐☐ cc 1 - 7 Questionnaire number (See code sheet)

☐☐☐☐☐☐ cc 8 - 13 Date (month/day/year)

☐☐☐☐ cc 14 - 17 Time (24 hour clock)

Good morning/afternoon/evening! I'm ______________________ from ACTION, the federal volunteer agency. I see you have picked-up one of those brochures on drug abuse prevention. May I ask you a few questions? It will take only five minutes of your time and it is quite important for us to know how good this brochure is. Would you please sign this consent form for this brief interview? (Have person sign consent form before proceeding.)

1. How did you find out about the brochure?

(Code all 7 — Put "0" for NO; "1" for YES)

☐ cc 18 1 Radio/TV
☐ cc 19 2 Newspaper
☐ cc 20 3 Poster in window
☐ cc 21 4 Word of mouth
☐ cc 22 5 Club/church/organization announcement
☐ cc 23 6 Just saw the display now
☐ cc 24 7 All of the above
☐ cc 25 8 Other ______________________
☐ cc 26 9 No response

2. Did you come to this pharmacy/drug store for another purpose or did you come just for the brochure?

☐ cc 27 1 Other purpose
2 Just for brochure
9 No response

Attachment C

CONSENT FORM

Drug Prevention Information Dissemination Evaluation

CONSENT TO BE INTERVIEWED

I agree to be interviewed as part of this regional study. I understand that my answers will be kept confidential, that anything I say will only be reported anonymously together with opinions from other people, and that I may refuse to answer any or all questions.

Signature: ______________________________

Printed name: ______________________________

Date: ______________________________

Attachment D

ACTION
WASHINGTON, D.C. 20525

November 12, 1982

Dear Participant:

Thank you very much for your help with the Drug Use Prevention Program Drug Prevention Information Dissemination Evaluation.

This information collection complies with the Privacy Act of 1974 and OMB Circular A-108, "Responsibilities for Maintenance of Records about Individuals by Federal Agencies," and is covered by the following Privacy Act system: ACTION Information Gathering System, ACTION AF/32. No permanent records will be kept which identify individual respondents.

Information you have furnished, and will furnish if you are called for the follow-up survey, will be used to provide research data to the ACTION Agency to find out how effective this brochure on drug abuse prevention is and how this and other projects may be improved. A statistical report will be issued but it will not contain your name or any information that could identify you.

If you have any comments or questions, feel free to contact ACTION's Evaluation Division at the following toll-free number: (800) 424-8580, extension 218.

Sincerely,

Mel E. Beetle

Melvin E. Beetle
Director
Evaluation Division
Office of Policy and Planning

Attachment E

FOLLOW-UP TELEPHONE SURVEY INSTRUMENT

DRUG PREVENTION INFORMATION DISSEMINATION EVALUATION

Follow-up Telephone Survery

☐☐☐☐☐☐☐☐T☐☐ cc 1 - 10	Questionnaire number (See code sheet)
☐☐☐☐☐☐ cc 11 - 16	Date (month/day/year)
☐☐☐☐ cc 17 - 20	Time (24 hour clock)

Good morning/afternoon/evening Mr./Mrs./Miss/Ms.______________________________

I'm ____from the ACTION Evaluation Division. Last month you picked-up the brochure on drug abuse prevention at the ____(exact name of pharmacy/drug store) and indicated we could phone you to ask your opinion of it.

1. Have you had the opportunity to read the brochure?

☐cc 21
- 0 No
- 1 Yes

2. Has anyone else in your family read the brochure?

☐cc 22
- 0 No
- 1 Yes
- 2 Uncertain

> **NOTE:** If the answer to question 1 is No, recommend that he/she read the brochure, thank him/her, and terminate.

3. Do you feel that the publication and distribution of this brochure is an effective way of fighting drug abuse?

☐cc 23
- 0 No
- 1 Yes
- 2 Uncertain
- 9 No response

4. Did you learn something about drug abuse prevention from the brochure that you didn't already know?

☐cc 24
- 0 No
- 1 Yes
- 2 Uncertain
- 9 No response

5. After having read the brochure, would you consider marijuana to be harmful or safe?

☐cc 25
1 Harmful
2 Safe
3 Undecided
9 No response

6. After having read the brochure, would you consider cocaine to be harmful or safe?

☐cc 26
1 Harmful
2 Safe
3 Undecided
9 No response

7. Are you more concerned or less concerned about drug abuse among children after having read the material?

☐cc 27
1 More concerned
2 Less concerned
3 No difference
9 No response

8. Do you think you would be able to recognize a drug user based on this material?

☐cc 28
0 No
1 Yes
2 Uncertain
3 No response

9. Do you now feel more comfortable and prepared to discuss the prevention of illegal drug use?

☐cc 29
0 No
1 Yes
2 Uncertain
9 No response

10. Are there any other drugs not mentioned in the brochure about which you would like to know more?

☐cc 30
0 No
1 Yes
9 No response

If yes, list.

☐cc 31 ________________
☐cc 32 ________________
☐cc 33 ________________

11. Your pharmacist has detailed information about drugs and drug abuse. Would you consult your pharmacist about drug abuse information?

☐cc 34 0 No
1 Yes
2 Undecided
9 No response

12. Would you consult any of the other resources mentioned at the end of the brochure?

☐cc 35 0 No
1 Yes
2 Undecided
9 No response

Have you?

☐cc 36 0 No
1 Yes
9 No response

13. Have you used the information from the brochure in any of these situations?

(Code all 8 — Put "0" for NO; "1" for YES)

☐cc 37 0 Not used

☐cc 38 1 Family

☐cc 39 2 School/PTA

☐cc 40 3 Church

☐cc 41 4 Boy/Girl Scouts

☐cc 42 5 Other Youth groups

☐cc 43 6 Civic groups

☐cc 44 7 Social groups

☐cc 45 8 Other________________________________

☐cc 46 9 No response

14. Would you feel comfortable sharing the information you have learned from the brochure with someone involved with drugs?

☐ cc 47
0 No
1 Yes
2 Uncertain
9 No response

15. Are you involved with volunteer groups that can use this kind of information?

☐ cc 48
0 No
1 Yes
9 No response

(NOTE: If no, ask question 16. If yes or no response, skip to question 17.)

16. After having read this brochure, do you think you would do volunteer work in the community in the area of drug abuse prevention?

☐ cc 49
0 No
1 Yes
2 Uncertain
9 No response

17. Is there anything else about the brochure or drug abuse prevention you would like to add to what we have just discussed?

☐ cc 50
0 No
1 Yes
9 No response

NOTE: If yes, what? ____________________________________

____

18. Thank you very much for your time and information. I do, however, have one more question before we finish. Would you have read this brochure had you not been interviewed at the store and consented to this telephone interview?

☐ cc 51
0 No
1 Yes
2 Uncertain
9 No response

Thanks again, good-bye.

☐☐☐☐ Time
cc 52 - 55

McNeil
Pharmaceutical
Spring House, PA 19477

Herbert W. Browne
Senior Vice President

September 26, 1984

Ms. Angie Hammock
Director
Drug Prevention Program
806 Connecticut Avenue, N.W.
Room 606H, Domestic Operations
Washington, D.C. 20525

Dear Angie:

I thought you might be interested in the following information which we have been able to obtain through telephone surveys and on-site monitoring by our sales force since the Pharmacists Against Drug Abuse pilot project was launched November 15, 1982.

During the week of December 3, 1982, 300 pharmacists were contacted by telephone and the information we received was:

> 90% of the pharmacists were displaying the brochures on the easels
>
> 90% indicated that customers were picking up the brochures and taking them home
>
> 58% of the pharmacists were using the window banner
>
> 60% of the pharmacists had read "A Pharmacist's Guide to Drug Abuse"
>
> 86% of the pharmacists had rated the program "good" to "excellent"

During the week of January 10, 1983, 170 pharmacists were visited by our sales reps to ascertain their participation in this program. The information we received was:

> 86% of the pharmacists were displaying the brochures in the easel
>
> 92% of the pharmacists said customers were picking up the brochures and taking them home
>
> 73% of the pharmacists had read "A Pharmacist's Guide to Drug Abuse"
>
> 93% said the program was "good" to "excellent"

During the week of March 28, 1983, a second survey of 200 retail stores was conducted by our sales reps to determine the extent of participation in the PADA program. The following information was obtained:

67% of the pharmacists were displaying the brochures in the easel

88% of the pharmacists had reordered or knew how to reorder brochures

48% of the pharmacists were using the "pocket savers"

37% of the pharmacists were displaying the window banner.

The pilot project was expanded to the balance of the New England area on June 15, 1983. During the week of July 27, 300 pharmacists in the expanded area were telephoned. Information gathered was as follows:

92% of the pharmacists were displaying the easel with the brochures

35% of the pharmacists were receiving questions from consumers who read the brochure

52% of the stores were displaying the window banner

70% of the pharmacists had read "A Pharmacist's Guide to Drug Abuse"

86% of the pharmacists felt that the program was "good" to "excellent"

During the week of September 12, our sales reps in the expanded area conducted a survey with the following results:

67% of the pharmacists were displaying the window banner

88% of the pharmacists were displaying the brochure

96% of the pharmacists had read "A Pharmacist's Guide to Drug Abuse"

92% of the pharmacists rated our program as "good" to "excellent"

90% of the pharmacists had reordered or knew how to reorder brochures.

When you consider these two sets of surveys were four months and eight months after the launch in November, 1982, the continued participation and cooperation of the pharmacists is most encouraging.

Over 500 pharmacists attended our training class in public speaking. Following these classes, over 300 agreed to act as spokespersons for us in the New England area.

Incidentally, the Laverdiere drug chain, which is the largest drug chain in Maine, has designed their entire advertising campaign for the next few months around the PADA program. In fact, they even have a contest on for tennagers to submit essays on drug abuse.

All of the above leads me to conclude that our pilot project has been very successful and should enjoy the same degree of success when we launch nationwide.

Sincerely,

Herb

HWB:ce

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Alcohol, Drug Abuse, and
Mental Health Administration
National Institute on Drug Abuse
5600 Fishers Lane
Rockville MD 20857

April 6, 1984

The Honorable Charles B. Rangel, Chairman
Select Committee on Narcotic
Abuse and Control
U. S. House of Representatives
Washington, D. C. 20515

Dear Mr. Chairman:

Enclosed are the answers to the questions raised in your December 1, 1983 letter. Perhaps after reviewing the attached material you may feel that a meeting to discuss these issues will be helpful.

Once again, thank you for the opportunity to testify at the November hearing, and if you have any additional questions about the Institute's programs please call me.

Sincerely yours,

William Pollin

William Pollin, M.D.
Director
National Institute on Drug Abuse

1. Overview of why there is such a wide difference in the perception of the drug abuse problem and resources available to address treatment and prevention needs.

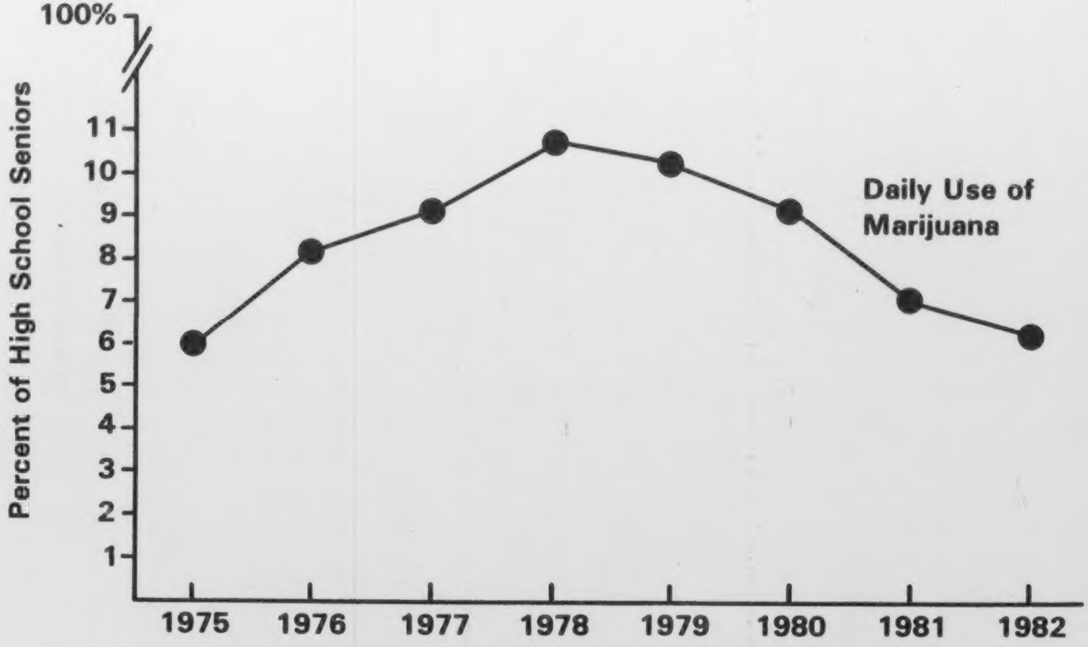
Widespread abuse of drugs in America continues to present serious health consequences for users and social and economic problems for the non-abusing public. Although precise estimates of the total impact of drug abuse remain difficult, there are valid and reliable indicators of the incidence and prevalence of the problem as well as measures of the health consequences to individual abusers. The National Institute on Drug Abuse (NIDA) as the lead Federal agency for drug abuse demand reduction, monitors on a national basis both the magnitude of the problem and the nature of these related adverse consequences. In addition, NIDA periodically assesses the level of resources available for prevention and treatment services. From these activities, the Institute gains what is believed an accurate perception of the Nation's drug abuse problem.

The Institute recognizes that information gathered to make national estimates may not always reflect local conditions. For example, the use of methaqualone has steadily declined in national prevalence surveys while some communities such as Miami, Florida, have experienced epidemic levels of use of this substance. Similarily, the use of stimulants has increased in some communities while decreasing in national reporting. Resources available to support local drug abuse treatment services also show variation between the national picture and that seen in specific areas. For example, findings of the National Drug and Alcoholism Treatment Utilization Survey (NDATUS) from 1980 and 1982 demonstrate that total financial support for drug abuse services has increased by 10 percent. However, drug abuse treatment service providers in 27 States reported less funding in 1982 than in 1980.

While national data may not reflect each and every local situation, it does provide a general assessment of the overall drug problem and the availability of prevention and treatment services. Nevertheless, it is possible that perceptions of the level of available resources may vary due to the time at which data is gathered. For example, funds appropriated by Congress in a particular fiscal year are not always used by service providers during that period. An Alcohol and Drug Abuse and Mental Health Services (ADMS) Block Grant allotment to a State may be effective as of October 1, but conceivably programs could receive these funds up to two years later since States need only obligate the ADMS Block Grant funds within a two year period. As a result, when NDATUS surveys treatment providers for the resources available, a proportion of the Federal funds awarded to a State during that particular fiscal year may be unreported.

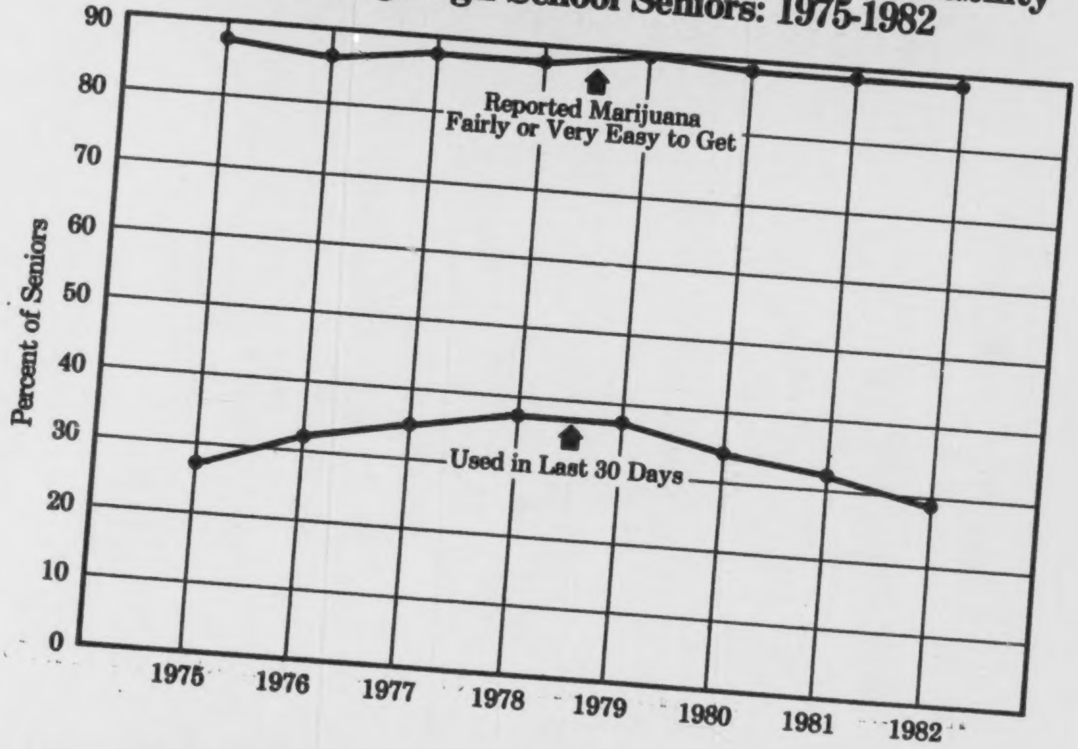
2. Copies of the charts Dr. Pollin used during his testimony at the November hearing appear on the following pages.

Daily Marijuana Use, U.S. High School Seniors, 1975-1982



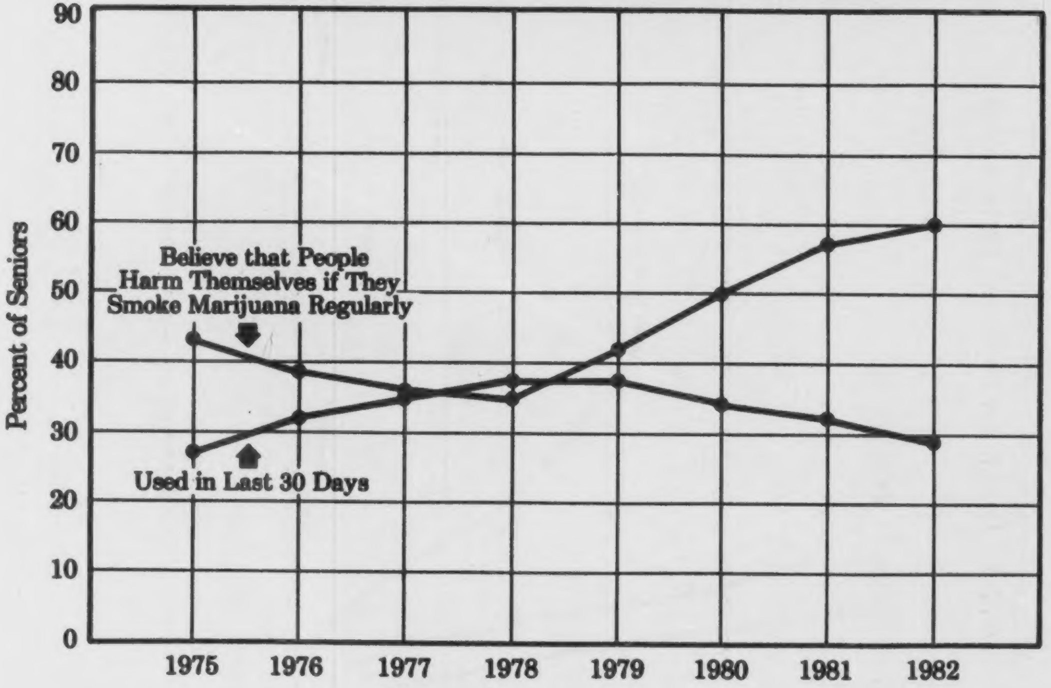
Source: National Institute on Drug Abuse, Data from *Student Drug Use in America,* 1982.

Trends in Marijuana Use and Perceived Availability Among High School Seniors: 1975-1982



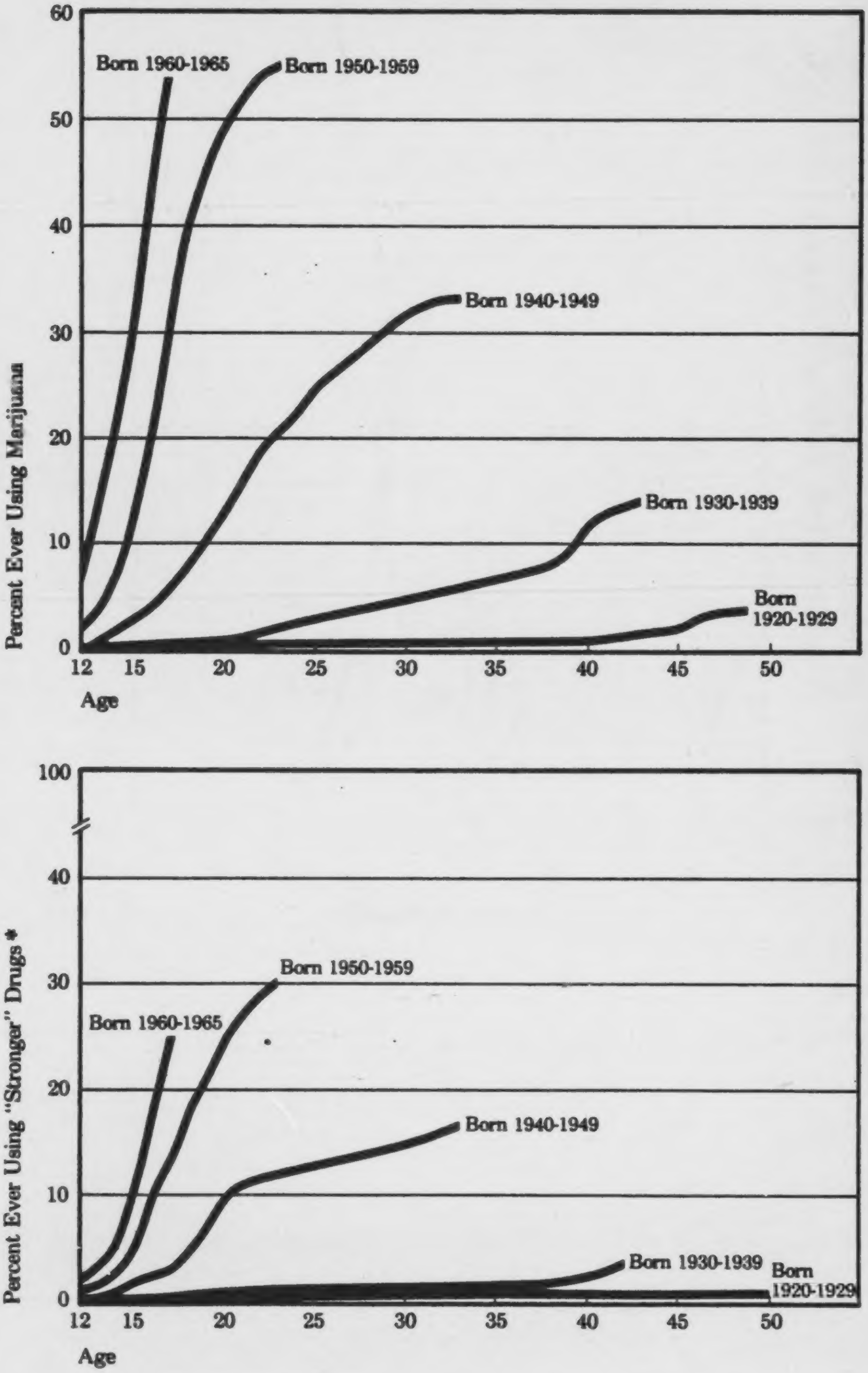
Source: National Institute on Drug Abuse, data from the Monitoring the Future study, 1982.

Trends in Marijuana Use and Perceived Harmfulness Among High School Seniors: 1975-1982



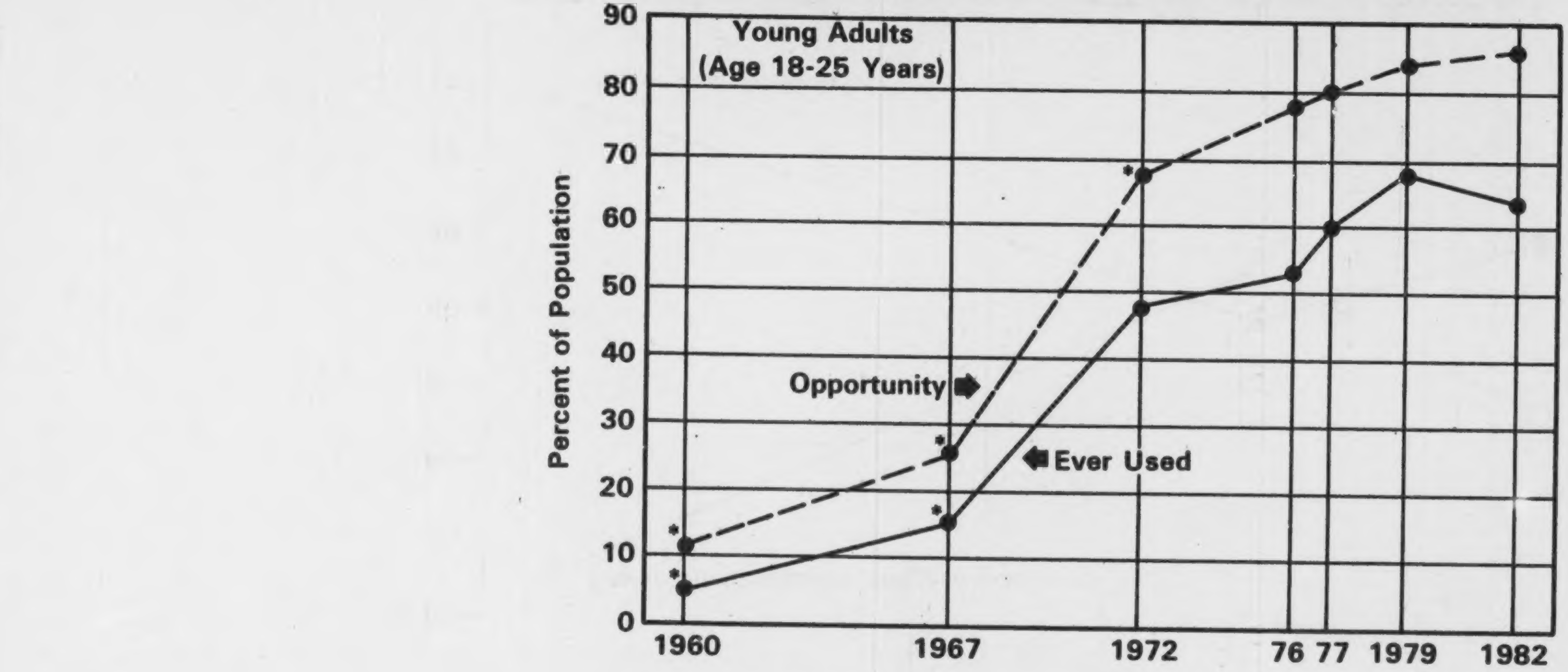
Source: National Institute on Drug Abuse, data from the Monitoring the Future study, 1982.

Lifetime Experience with Marijuana and "Stronger" Drugs for Selected Birth Cohorts



* Includes non-medical Rx, cocaine, hallucinogens, heroin

Opportunity to Try Marijuana and Lifetime Experience, Young Adults: 1982

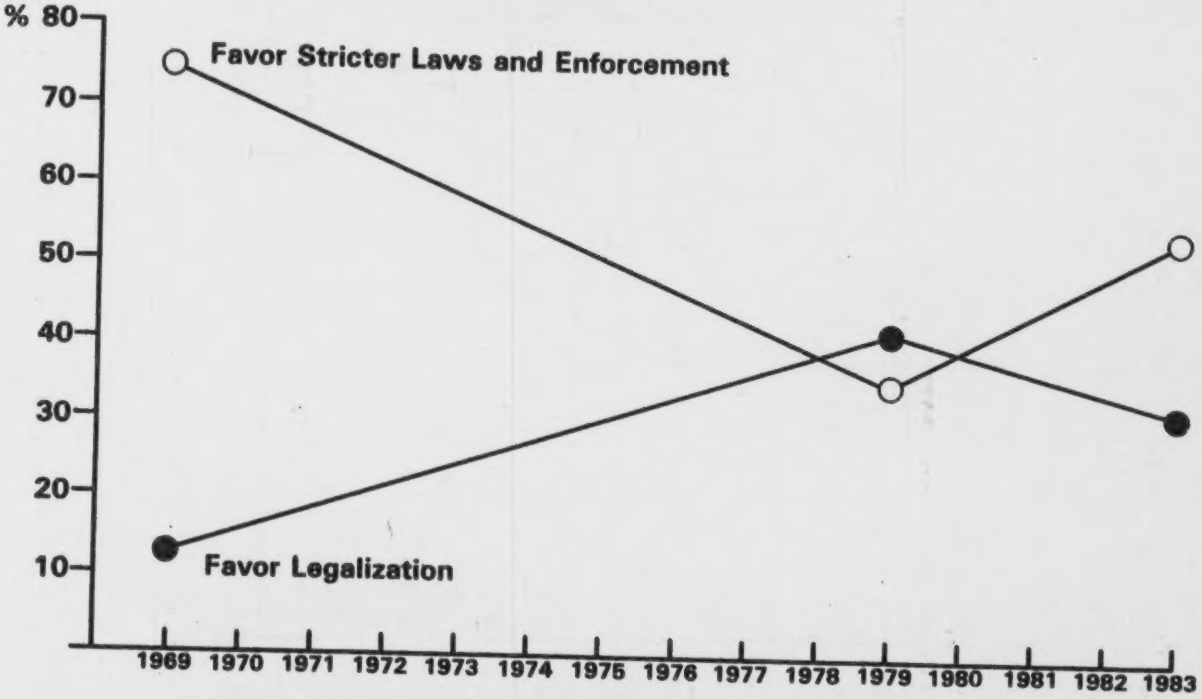


*"Projection" Based on Reconstructed Data.

Source: National Institute on Drug Abuse, Data from the *National Survey on Drug Abuse.*

California Survey*

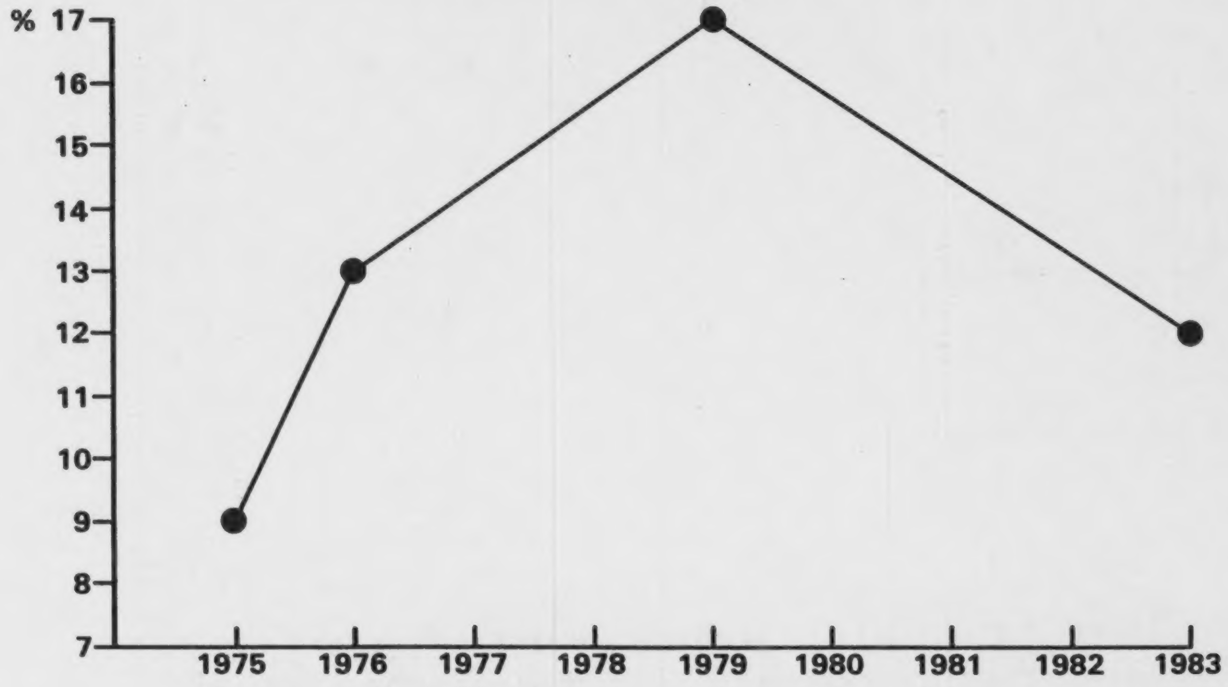
Public Attitudes Toward Marijuana Laws



*Source: *California Opinion Index*, August 1983

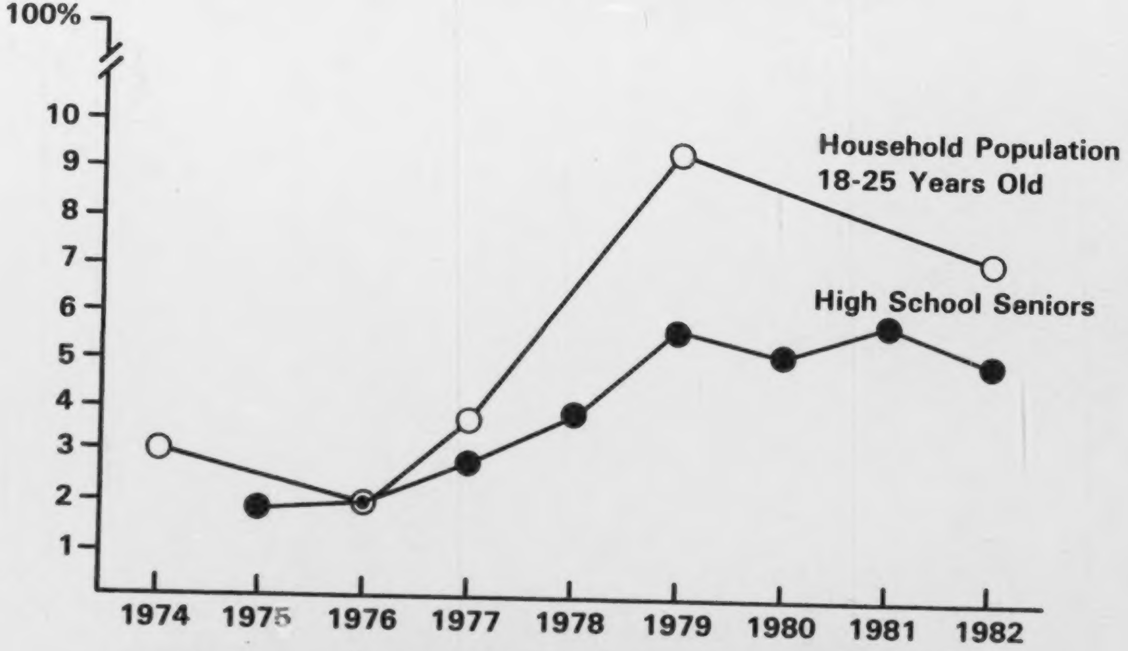
California Survey*

Marijuana Use Trends Among Adult Smokers, 1975-1983



*Source: *California Opinion Index,* August 1983

Current Cocaine Use, U.S. Household Population and High School Seniors, 1974-1982



Source: National Institute on Drug Abuse. Data from the *National Survey on Drug Abuse* and *Student Drug Use in America*, 1982.

3. Please provide 1983 DAWN data supporting the conclusion that heroin and cocaine trends are leveling off.

Drug use by Americans has permeated most segments of society so thoroughly that it is sometimes difficult to reconcile how overall usage trends can be distinguished from perceptions of the adverse consequences to individuals and society. While it is true that health effects are related to overall prevalence trends, the relationship between the two is confounded by the behavior of those already engaged in drug abuse patterns known to result in serious adverse health consequences. As a result, it is not possible to directly establish incidence and prevalence trends through health consequence data such as that from the DAWN data system. However, these data can sometimes provide an indirect measure of drug use patterns. The following graphs show total heroin mentions (Figure 1) and total cocaine mentions (Figure 2) reported by emergency rooms each month for the period August 1980 through July 1983. Both graphs provide a fitted regression line for the three year period as well as a fitted line for the past 12 months. The results suggest that the rate of increase in both heroin and cocaine mentions had stabilized between July of 1982 and July, 1983. That is, while the overall three year trend in DAWN mentions of both heroin and cocaine increased, the trend in the last 12 months shows signs of leveling off. A more recent review of new data through September 1983 indicates that once again emergency room mentions of heroin and cocaine may be increasing. At the time the testimony was developed, the short term (12 month) trend line suggested a leveling of adverse health consequences associated with the use

FIGURE 1

National Institute on Drug Abuse

Total Heroin Mentions by Month
Imputed Data
DAWN: August 1980 — July 1983

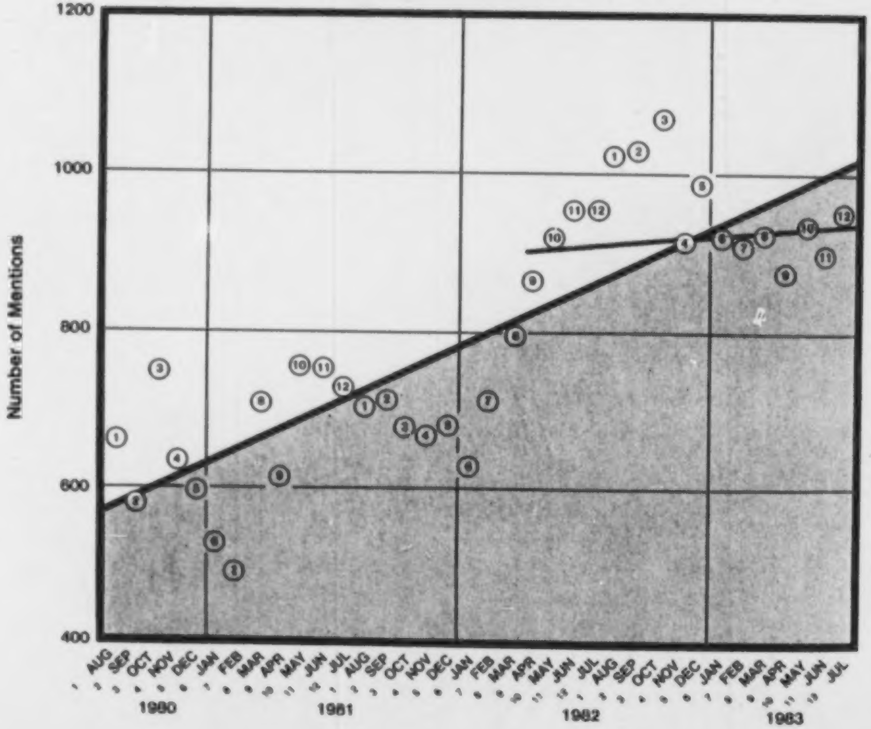
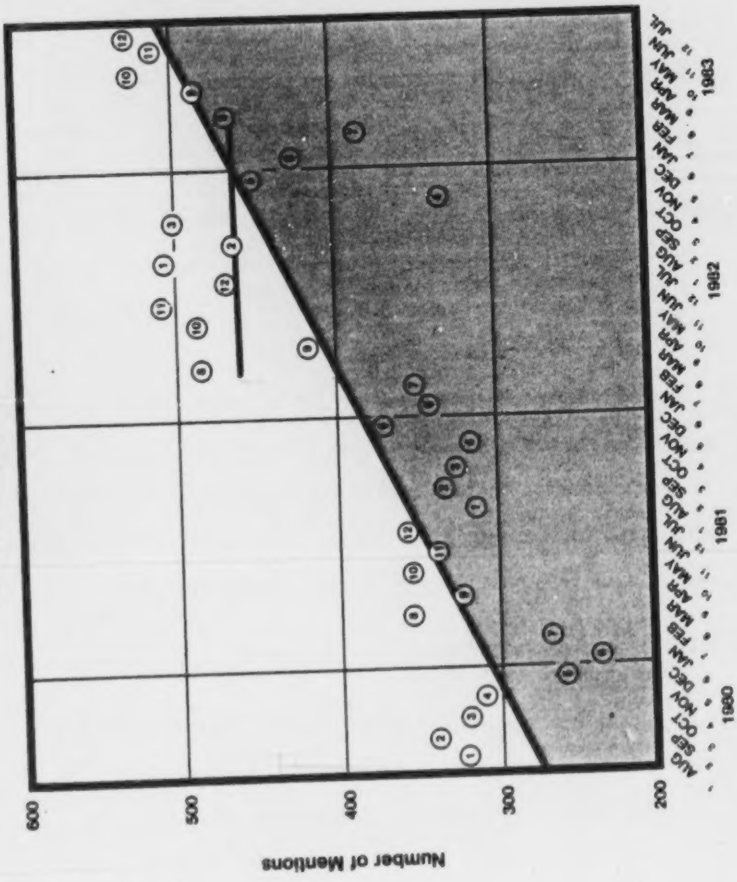


FIGURE 2

National Institute on Drug Abuse

Total Cocaine Mentions by Month
Imputed Data
DAWN: August 1980 — July 1983



of both cocaine and heroin. However, more recent data suggest that consequences associated with the use of these drugs is rising once again.

4. Please provide data on cocaine deaths in New York City.

The only data available for cocaine deaths in New York City are from medical examiner reports and the Drug Abuse Warning Network (DAWN). Unfortunately, the medical examiner in New York City has not reported to the DAWN data system since the first calendar quarter of 1982. Thus, 1981 is the last full year for which cocaine death data are available. In 1981, there were 140 cocaine related deaths reported for the New York area. At this time, we are negotiating with the City of New York to obtain medical examiner data. Dr. Sencer, Commissioner of Health for New York, has recognized the importance of these data as well as a willingness to provide them to NIDA, however, data from New York are still unavailable to us.

5. Please provide an analysis of the Household Survey and the High School Senior Survey which includes the following points:

   o are sample sizes large and diverse enough to be truly representative?

   o is the High School Senior Survey able to determine the severity of drug use among younger children?

   o is the Household Survey an effective tool for measuring use of heroin?

   o what other factors introduce bias into the results of these surveys?

Together with our health consequence studies, the National Household Survey and the High School Senior Survey constitute the cornerstone of our epidemiological program. Both surveys provide valid trend data on the extent of drug abuse by Americans which has been confirmed by other governmental surveys and private polls.

The National Household Survey is a personal interview survey of persons age 12 and older living in households in the coterminous United States. For purposes of analysis, the 1982 sample of 5,624 household residents was divided into three groups: youth aged 12 to 17; young adults between 18 and 25; and, adults aged 26 and older. In addition, the Household Survey sample was designed to insure that part of the 5,624 respondents was found among each of the Nation's largest 25 metropolitian areas.

The size of the Household Survey sample is considerably larger than that used for many national surveys. Scientifically, it is truly representative of the nation and confidence can be assured in using the results. Construction of the sample followed state-of-the-art survey research methods guided by experts in the drug abuse and survey research fields. Through oversampling of the young adult population, the survey is able to detect drug use involving most substances, although the study cannot reliably be used for heroin. Other methods must be utilized to estimate the prevalence of this drug. There are three reasons why the Household Survey cannot be used to estimate the prevalence of heroin in the population. First, the actual number of heroin addicts represents less than one-half of one percent of the nation's population. Thus, the size of the heroin using population is too small to be accurately estimated by a survey of this type. Secondly, among all substances, heroin probably is the most commonly underreported. Studies have shown that heroin addicts will deny use of heroin while acknowledging other drug use in situations similar to the self-report interview used in the National Survey. Finally, a substantial portion of heroin addicts may be outside the traditional American household population. With the probable exception of heroin, the effect of the excluded populations on prevalence estimates, or in establishing trends, is small, since the Household Survey sample is representative of nearly 98 percent of Americans age 12 and older.

The response rates achieved in the 1982 National Survey, by age cohort were:

- Youth (12 to 17) --- 84%
- Young Adults (18 to 34) -- 81%
- Adults (35 and older) -- 77%

Factors having a negative effect on the response rate include: refusal to participate, language difficulty, respondents not at home, and senility. Interviewers confronted with one of these situations were not permitted by the research design to substitute other persons or other households. Overall the National Survey meets the standards set by the American Statistical Association's (ASA) "Pilot Project on the Assessment of Survey Practices and Data Quality in Surveys of Human Populations." Through this publication the ASA established voluntary standards for sample design specifications, adequacy of response rates, verification of interviewing, quality control over data processing and proper calculation of statistics.

Estimates of the percentage of Americans using any particular substance are derived by projecting the prevalence rates found in the scientifically drawn sample to the nation's residents. These population projections are considered valid within specified confidence limits. The upper and lower confidence limits define the interval within which one can be 95 percent certain that the true population value lies. That is, if the survey were conducted in all possible samples, the statement that the population value lies in the confidence interval would be correct 95 times out of 100.

The High School Senior Survey produces estimates of the prevalence of drug use based on a sample of seniors drawn from 125 to 140 high schools throughout the United States. In the 1982 High School Senior Survey, 15,488 students responded from 137 schools. Both public and private schools are selected for the sample. Schools within specified geographic areas are asked to participate for a two year period and since 1975, from 66 percent to 80 percent of the schools invited to participate have agreed to do so. For each school refusing, a similar school (in terms of size, geographic area, urbanicity, etc.) is selected as a replacement. The selection of replacement schools, in theory, removes problems of bias by region, such as urbanicity or ethnicity, that might result from certain schools refusing to participate. Other potential biases are more subtle, however. If, for example, it turned out that most schools with "drug problems" refused to participate, that would seriously bias the sample. And if any other single factor were dominant in most refusals, that also might suggest a source of serious bias. In fact, however, the reasons for a school refusing to participate have been varied and are often a function of happenstance events; only a small proportion specifically object to the drug content of the survey. As a result, NIDA is confident that school refusals have not biased the surveys.

Student participation has ranged from 77 percent to 83 percent of all sampled students in participating schools each year. The single most important reason students are missed is absence from class at the time of data collection. Another source of missing data is due to individual student refusal to complete a questionnaire, which amounts to about 1 percent of the target sample.

The accuracy of estimates based on the High School Senior Survey average about (+/-) 1 percent with confidence intervals varying from (+/-) 2.2 percent to less than (+/-) 0.2 percent depending on the substance. This means that if all American high schools were surveyed and all senior students participated, the results from such a massive survey should be within about one percentage point of the published findings for most drugs at least 95 times out of 100. This high level of accuracy permits the detection of relatively small changes from one year to the next.

Like any other scientific study, the Institute's two national surveys have limitations. Results of the surveys cannot be generalized to populations other than their respective target populations. Results from the High School Senior Survey cannot be used to reflect drug use of school dropouts or younger children. Similarly, results from the Household Survey do not reflect drug use by persons not living in households, although school dropouts and younger teenagers are included.

To address the possibility that school dropouts could substantially bias the High School Senior Survey, the Institute convened a Technical Review in 1982 to consider this problem and produce adjusted estimates if appropriate.

Table 1

Lifetime Drug Use Estimates
Among High School Seniors and Their Same Age Peers, 1981

	Seniors Present	Dropouts Only			Total Population		
		A*	B*	C*	A*	B*	C*
Alcohol	92.6	95.4	96.8	98.2	93.4	93.7	93.9
Cigarettes	71.0	80.0	84.5	89.0	73.7	74.4	75.1
Marijuana	59.5	74.8	82.5	90.1	64.1	65.2	66.4
Amphetamines	32.2	45.2	51.7	58.2	36.1	37.1	38.1
Cocaine	16.5	27.8	33.5	39.1	19.9	20.7	21.6
Tranquilizers	14.8	21.6	25.0	28.4	16.8	17.4	17.9

* Estimates using one of the following assumptions:

A -- Dropouts use drugs at the same rate as absentees

B -- Dropouts use drugs half again as much as absentees

C -- Dropouts use twice as much as absentees

Since students with higher absentee rates tend to have higher than average rates of drug use it was concluded that missing them is likely to have some effect on drug use estimates. Accordingly, adjusted estimates of the effect of absentees and dropouts were studied. For example, a senior attending classes only 10 days out of the past 20 school days was assigned a "weight" twice as heavy than a senior not absent during the past 20 days. Assuming that a random sample of seniors with high rates of absenteeism were present on the day the survey was administered, a separate estimate of the prevalence of drug use among all "absentees" was calculated. The results indicated that the observed prevalence of cigarette use was understated in the high school survey by about 2 percent to 4 percent, and marijuana use was underestimated from 5 to 7 percent. Table 1 presents estimates of drug use for selected substances among a combined population of seniors, absentees and dropouts.

While adjustments for bias are important in assessing the absolute magnitude of yearly estimates, they have little or no effect on assessing trends in drug use by seniors over time. This is true because the effect on the trend lines in drug use will be consistent as it is assumed the same level of distortion exists each year. For example, the percentage of persons in the general population aged 16 to 24 not completing, nor actively enrolled, in high school has remained at about 15 percent between 1970 and 1980. Similarly, treatment admission data collected in three large-scale national samples demonstrates that the percentage of clients not completing high school has remained the same between 1969 and 1981.

As shown in Table 1, even though drug use may be considerably higher among absentees and dropouts, a high level of use within a comparatively small proportion of the general population has little impact on the overall estimates. Hence, the conclusion that trends from year-to-year are not affected since the adjustments for unsampled groups are likely to remain constant from one year to the next. It is also important to note that estimates of the statistical accuracy of the sample do not reflect the "coverage" issue described above. That is, even though the High School Senior survey results are not representative of similarly aged persons whom have left school, this has no effect on the accuracy of estimates made as a result of conducting the survey with a sample of seniors currently enrolled and present on the day the survey was administered.

As noted, alternative methods of producing prevalence estimates of the extent of heroin use are employed. Over the past decade, NIDA has developed procedures for measuring heroin prevalence based on a number of indirect indicators. Such factors as the price and purity of heroin, the number of deaths and hospital emergency room mentions attributable to heroin, the number of heroin related arrests, and the number of addicts in treatment provide data from which indirect estimates are made. Although based on indirect measures, these estimates are generally thought to provide useful information on the magnitude of heroin use, thus providing information for planning and evaluation purposes.

The Institute will continue to refine methods to estimate the extent of drug use among both the general population and other subgroups including heroin addicts and younger school age children. In fact, a national survey of junior high school students has been proposed for 1986 to complement prevalence estimates from the youth cohort of the National Survey.

In summary, both national surveys are conducted with the highest of scientific rigor and are capable of accurately estimating the prevalence of drug abuse in the populations they are designed to measure. While it is true that some high using groups are excluded from the surveys, it has been determined that the effect of the exclusions on overall findings is minimal.

6. What other studies, beside the 1983 California Opinion Index reflect reduced prevalence trends?

The Maryland Department of Health's, 1982 Survey of Drug Use Among Maryland Adolescents also reports a trend of gradual reduction in cigarette and marijuana use since 1978. During this period, the Maryland survey reported that the use of cigarettes fell about 5 percent (36.8 percent to 31.7 percent) while marijuana use declined some 10 percent (44.0 percent to 33.9 percent). National High School Senior Survey results between 1978 and 1983 show a 7 percent drop in current cigarette use and a 10 percent reduction in current use of marijuana. However, there is some reason to question whether the trend in cigarette smoking is continuing to decline, as the current use of cigarettes by high school seniors has remained at 30 percent since 1982.

Estimates of drug use among personnel in the Armed Services have been produced for 1980 and 1982. Findings of the 1982 military survey indicate dramatic reductions in the percent of servicemen using marijuana and cocaine. Reported use of cocaine during the past month fell by one-half among servicemen aged 18 to 25, while marijuana use declined from 40 percent in 1980, to 25 percent in 1982. While not as dramatic, drug use estimates for these substances in a matched group of civilians (from the 1979 Household Survey) also fell between 1979/1980 and 1982. Marijuana use in the past month declined from 42 percent in 1979/1980 to 35 percent in 1982, while cocaine use dropped from 10 percent in 1979/1980 to just over 9 percent in 1982.

A recently released Gallup Poll provides additional evidence that prevalence trends for some substances are continuing to decline.

7. Please provide a State-by-State analysis of Federal funds received under the ADMS Block Grant for Fiscal Years 1982-1984.

    o how do block grant awards compare to predecessor categorical grant awards?

When Congress enacted the Alcohol and Drug Abuse and Mental Health Services (ADMS) Block Grant program in 1981, it provided the method for determining the relative share for each eligible recipient. The method essentially gave each State the same proportion of total Federal Alcohol, Drug Abuse, and Mental Health (ADM) funds which existed in a "base year", established by statute as 1980 for alcohol and drug abuse programs and 1981 for mental health programs.

The block grant legislation also prescribed the relative share of each State's allotment which was to be made available for either mental health or substance abuse programs. Further, the statute established minimum amounts each State was to make available for either alcohol or drug abuse activities, and specified an "earmark" for prevention activities.

Table 2

DISTRIBUTION OF FY 1982 ADMS BLOCK GRANT

(Dollars in Thousands)

	1980 NIDA	FY 1982 ADMS	Mental Health	Substance Abuse	35 Pct. Minimum	30 Pct. Discretionary
Alabama	2,487	8,660	5,785	2,875	1,006	863
Alaska	472	1,772	220	1,522	533	457
Arizona	3,542	8,356	3,861	4,495	1,573	1,349
Arkansas	1,223	5,822	3,836	1,986	695	596
California	26,938	41,196	13,718	27,478	9,617	8,243
Colorado	2,123	6,349	2,906	3,443	1,205	1,033
Connecticut	4,744	6,481	2,253	4,228	1,480	1,268
Delaware	902	1,130	51	1,079	378	324
Dist. of Col.	1,913	2,102	91	2,011	704	603
Florida	10,000	22,445	11,768	10,677	3,737	3,203
Georgia	2,727	8,969	6,004	2,965	1,038	890
Hawaii	1,034	2,367	1,179	1,188	416	356
Idaho	375	1,250	456	794	278	238
Illinois	6,229	16,251	9,172	7,079	2,478	2,124
Indiana	2,313	18,117	15,537	2,580	903	774
Iowa	1,814	2,029	34	1,995	698	598
Kansas	597	3,018	1,635	1,383	484	415
Kentucky	1,146	3,322	969	2,353	824	706
Louisiana	3,243	4,354	601	3,753	1,314	1,126
Maine	628	3,284	1,635	1,649	577	495
Maryland	2,719	3,596	295	3,301	1,155	990
Massachusetts	5,952	17,025	9,355	7,670	2,685	2,301
Michigan	9,263	13,095	3,695	9,400	3,290	2,820
Minnesota	2,122	3,553	869	2,684	939	805
Mississippi	707	3,960	2,825	1,135	397	340
Missouri	2,565	8,010	4,551	3,459	1,211	1,038
Montana	657	1,742	864	878	307	263
Nebraska	619	2,115	920	1,195	418	358
Nevada	1,205	2,624	1,187	1,437	503	431
New Hampshire	766	3,468	2,477	991	347	297
New Jersey	10,414	19,299	9,783	9,516	3,331	2,855

Table 3

DISTRIBUTION OF FY 1983 ADMS BLOCK GRANT

(Dollars in Thousands)

	1980 NIDA	FY 1983 ADMS	Mental Health	Substance Abuse	35 Pct. Minimum	30 Pct. Discretionary
Alabama	2,487	9,449	6,400	3,049	1,067	915
Alaska	472	2,120	503	1,617	566	485
Arizona	3,542	9,122	4,353	4,769	1,669	1,431
Arkansas	1,223	6,468	4,361	2,107	737	632
California	26,938	44,368	15,223	29,125	10,201	8,744
Colorado	2,123	7,095	3,445	3,650	1,278	1,095
Connecticut	4,744	7,077	2,592	4,485	1,570	1,346
Delaware	902	1,446	299	1,147	402	344
Dist. of Col.	1,913	2,499	363	2,136	748	641
Florida	10,000	24,345	13,022	11,323	3,936	3,397
Georgia	2,727	9,885	6,740	3,145	1,101	944
Hawaii	1,034	2,865	1,604	1,261	441	378
Idaho	375	1,441	599	842	293	253
Illinois	6,229	17,400	9,892	7,508	2,628	2,252
Indiana	2,313	19,778	17,041	2,737	958	821
Iowa	1,814	2,321	203	2,118	741	635
Kansas	597	3,496	2,032	1,464	512	439
Kentucky	1,146	3,702	1,206	2,496	874	749
Louisiana	3,243	4,708	726	3,982	1,394	1,195
Maine	628	3,781	2,031	1,750	613	525
Maryland	2,719	4,035	531	3,504	1,266	1,051
Massachusetts	5,952	18,476	10,341	8,135	2,847	2,441
Michigan	9,263	14,143	4,175	9,968	3,489	2,990
Minnesota	2,122	4,096	1,246	2,850	998	855
Mississippi	707	4,540	3,336	1,204	421	361
Missouri	2,565	8,803	5,136	3,667	1,283	1,100
Montana	657	2,181	1,251	930	326	279
Nebraska	619	2,364	1,096	1,268	444	380
Nevada	1,205	2,934	1,409	1,525	534	458
New Hampshire	766	3,894	2,843	1,015	368	315
New Jersey	10,414	20,915	10,821	10,094	3,533	3,028

Table 4

DISTRIBUTION OF FY 1984 ADMS BLOCK GRANT

(Dollars in Thousands)

	1980 NIDA	FY 1984 ADMS	Mental Health	Substance Abuse	35 Pct. Minimum	30 Pct. Discretionary
Alabama	2,487	9,328	6,318	3,010	1,054	903
Alaska	472	2,093	496	1,597	559	479
Arizona	3,542	9,004	4,297	4,707	1,647	1,412
Arkansas	1,223	6,385	4,305	2,080	728	624
California	26,938	43,808	15,031	28,777	10,072	8,633
Colorado	2,123	7,004	3,400	3,604	1,261	1,081
Connecticut	4,744	4,744	2,558	4,427	1,549	1,328
Delaware	902	1,428	295	1,133	397	340
Dist. of Col.	1,913	2,467	359	2,108	738	632
Florida	10,000	24,033	12,855	11,178	3,912	3,353
Georgia	2,727	9,757	6,652	3,105	1,087	932
Hawaii	1,034	2,827	1,583	1,244	435	373
Idaho	375	1,423	582	831	291	249
Illinois	6,229	17,400	9,892	7,508	2,628	2,252
Indiana	2,313	19,524	16,822	2,702	946	811
Iowa	1,814	2,292	201	2,091	732	627
Kansas	597	3,451	2,005	1,446	506	434
Kentucky	1,146	3,654	1,190	2,464	862	739
Louisiana	3,243	4,648	716	3,932	1,376	1,180
Maine	628	3,733	2,005	1,728	605	518
Maryland	2,719	3,982	524	3,458	1,210	1,037
Massachusetts	5,952	18,240	10,209	8,031	2,811	2,409
Michigan	9,263	13,962	4,122	9,840	3,444	2,952
Minnesota	2,122	4,043	1,229	2,814	985	844
Mississippi	707	4,481	3,293	1,188	416	356
Missouri	2,565	8,690	5,070	3,620	1,267	1,086
Montana	657	2,153	1,235	918	321	275
Nebraska	619	2,333	1,082	1,251	438	375
Nevada	1,205	2,897	1,391	1,506	527	452
New Hampshire	766	3,844	2,806	1,038	363	311
New Jersey	10,414	20,647	10,683	9,964	3,487	2,989
New Mexico	2,018	4,934	2,461	2,473	866	742

Within these parameters States were permitted increasing flexibility in Fiscal Years 1983 and 1984, at which time the legislation required only 95 percent and 85 percent respectively of a State's total allotment be subject to the "earmarks" for mental health and substance abuse. Consequently, States were permitted to transfer a portion of their ADMS Block Grant allotment to support any ADM activity not specifically prohibited by other sections of the law [e.g., Section 1914(b) (1) to (5) which prohibit cash payments to recipients; to other than not-for-profit organizations; etc.].

While these legislatively established guidelines allow flexibility in the use of funds, the total Federal funds received by each State under the ADMS Block Grant program varied from 1982 to 1984 only as a result of differing national appropriation levels. Tables 2, 3, and 4 chart the Federal funds received by each State under the ADMS Block Grant program from 1982 to 1984. When reviewing these Tables, it should be remembered that States have no requirement to report obligations to individual service providers. Instead, States are required to assure that use of block grant funds will be consistent with provisions of the legislation. In addition, States must eventually furnish copies of financial audits detailing the exact distribution of ADMS Block Grant funds among the three ADM services. Accordingly, the accompanying Tables present total maximum and minimum amounts applicable to each State by virtue of the block grant statute. For instance, Table 2 shows that the distribution of Fiscal Year 1982 ADMS Block Grant funds to Alabama was $8,660,000. The amount "earmarked" for mental Health ($5,785,000) and substance abuse ($2,825,000) is derived from a historical proportion of Federal ADM funds received in the "base" year. The substance abuse amount is further displayed according to the legislative requirement that at least 35 percent of a State's substance abuse portion be made available for alcohol programs; at least 35 percent of the substance abuse portion be made available for drug abuse programs; and the remaining 30 percent can be available, at the State's discretion, for support of either alcohol or drug abuse programs. For purposes of comparison, each Table also displays the amount each State received under predecessor categorical grant programs for drug abuse services in the "base" year of 1980.

8. How has the research budget been affected by budget cuts in recent years?

   - How many research projects were funded in 1984 compared to other recent years?
   - How many new projects were funded in 1984 compared to other recent years?
   - Were there projects in promising new areas of inquiry for which NIDA was unable to support due to lack of funds?
   - Which areas of our research program have suffered most due to recent budget cuts?
   - Why hasn't the Administration placed a high priority on drug abuse research?

When the ADMS Block Grant program consolidated drug abuse prevention and service programs, NIDA's total budget was reduced by approximately $186 million. The bulk of these funds were in turn awarded to States for support of community-based prevention and treatment services through the ADMS Block Grant program. However, other activities were subsumed at reduced levels into NIDA's research and direct operations budget. These included programs such as technical assistance, prevention research and demonstration, and treatment effectiveness studies. At the same time, NIDA's research budget was reduced from Fiscal Year 1981 to 1982 by approximately $3.6 million. Consequently, prevention research and treatment effectiveness studies competed as all other research activities for support from a smaller funding base.

The Institute's research budget increased to $47.5 million in Fiscal Year 1983, and to $54.6 in 1984 allowing an increase in the number of new and competing research projects each year. Whereas the Institute had supported 134 new and competing projects in 1980 only 79 were funded in 1981 and 73 in 1982. By Fiscal Year 1983, total projects had increased again to 97 and it is anticipated that 110 will be supported in Fiscal Year 1984.

The Institute has continued support for ongoing investigations in the preclinical areas, while initiating new areas of inquiry. New projects in prevention research and epidemiology have also been initiated which reflect changing needs and methods.

The high priority placed on drug abuse research by the Administration was reflected in the increase in funds requested from Fiscal Year 1983 to 1984. However, the $1.6 million reduction from the President's budget request appropriated by the Congress for Fiscal Year 1984 will delay continued recovery in NIDA's research budget. That drug abuse research continues to represent a high priority in the Administration is reflected by the 12.8 percent increase requested for NIDA in the President's FY 1985 budget. This increase for NIDA, the largest of any research program in the Public Health Service, is requested when the PHS overall budget request falls some 3 percent below its FY 1984 appropriation level.

9. How have research findings in the area of marijuana and health; the role of cigarette smoking in the onset of marijuana and other drugs; and biological factors in drug abuse contributed to advances in treatment and prevention approaches?

   - What new approaches have been developed?
   - If none, then how long before these findings can be translated into new treatment and prevention approaches?

In recent years, it has become increasingly clear that there exists a wide range of similarities in the development of various habitual behaviors. Converging lines of research indicate that cigarette smoking is a gateway drug for the onset of marijuana smoking, and subsequent use of other drugs. That is, drug use appears to be initiated in a sequential manner -- tobacco, alcohol, marijuana, inhalants, tranquilizers, barbiturates, amphetamines, cocaine, and heroin. Research at the University of Southern California has found tobacco smoking to be the strongest predictor of future marijuana smoking. In a secondary analysis of the High School Senior Survey, researchers at the University of Kentucky report that 93 percent of seniors who smoke cigarettes also report regular use of marijuana. In contrast, only 37 percent of males and 17 percent of females who have never smoked cigarettes have ever tried marijuana. Other research has shown that current use of cigarettes by alcohol users increases the propensity to initiate marijuana use by 30 percent to 60 percent. There is a greater contribution of cigarette use over alcohol use in determining a persons propensity to initiate marijuana use; and early initiation into marijuana is associated with subsequent initiation to other drugs. Similar findings from the National Household Survey support the notion that there is a typical order of sequence in which young people usually try various classes of drugs. Teenagers usually begin drug use by trying alcohol and /or cigarettes (Stage 1). Once having gained personal experience with these substances it becomes more likely that the youngster will progress to trying marijuana (Stage 2), and subsequently go on to use of one or more other drugs (Stage 3).

In this ordered sequence of new drug experience, each stage becomes almost a necessary condition for going on to the next highest stage. For example, among young adults, alcohol and/or cigarette use preceded marijuana histories that could be classified as to sequence of first use. Likewise, marijuana use preceded first use of a "Stage 3" drug for about 90 percent of the young adults who reported trying one or more drugs.

Based on these findings, NIDA has concluded that early prevention efforts targeted toward reducing young people's initiation into cigarettes can have long-term beneficial effects not only in reduction of smoking but also in the use of all other drugs.

Application of these findings in other NIDA sponsored research has led to development of effective means of preventing smoking and tobacco use among children and adolescents. For instance, results from several school-based prevention programs indicate that interventions based on social learning and developmental theories may be effective in training children to resist pressures to smoke cigarettes. These approaches have been effective in preventing or delaying the onset of smoking for as long as 2 years.

Other NIDA research has resulted in adapting promising smoking prevention approaches to the prevention of alcohol and other drugs of abuse. Among these are social skills interventions such as classroom strategies which help students improve self-management, decision making, and other life skills. Follow-up studies are needed to determine if these approaches need to be repeated for these youngsters in later years to sustain the preventive effect.

Additional future research priorities include further exploration of social pressures and life skills approaches which focus on different cultural and ethnic groups, youth becoming alienated from school and home, and among children who have dropped out of school.

Research findings concerning the biological factors in drug abuse also contribute to advances in treatment services, although application of these findings require more time to implement than advances in prevention or social rehabilitation approaches. Traditionally, treatment services have concentrated on reducing drug abuse, illegal activity and social dysfunction while restoring a client's ability to engage in healthful and productive activities. Over the years the effectiveness of drug abuse treatment services has been documented in three major scientific studies. Each study has concluded that treatment services have been responsible for successful treatment outcomes, largely as a function of time in treatment. That is, the longer an individual stays in treatment the better his chances of achieving and maintaining a successful outcome.

Given evidence that treatment service provided in any of the traditional modalities is effective _if_ clients can be retained in treatment, efforts to attract clients into treatment and keep them for some period of time are essential. In this regard, evidence that services that include chemotherapeutic adjuncts in the treatment process retain the greatest number of patients for the longest period of time is reflected by NIDA's continued research into the biological basis of addiction.

While the introduction of new pharmacologic agents is dependent on the lengthly process of new drug development, NIDA's efforts in developing new drugs over the past decade hold the promise of significantly advancing treatment services for opiate dependent persons. In recent years three new drugs have been studied by the Institute's intramural research facility, now located in Baltimore, Maryland. A brief description of these substances and their potential usefulness in clinical practice is summarized below.

LAAM: For many years heroin addicted individuals were treated by abrupt or gradual discontinuation of heroin, a form of treatment which involved serious withdrawal symptoms. Methadone was synthesized during World War II and it was found that it could be used in place of heroin in addicted persons to relieve withdrawal symptoms. Although methadone has several advantages over heroin, its use in therapy still posed many problems. For example, for some clients it is necessary to use large doses to suppress craving for 24 hours, it still involves daily drug taking behavior, and it can itself be abused. It was clear, therefore, that a longer lasting medication would have many practical therapeutic advantages. One of the first drugs to be studied extensively was L-alpha-acetyl-methadol (LAAM) because of its high oral effectiveness and long, smooth mode of action.

Because of LAAM's long duration of action, the frequency of visits to treatment facilities can be reduced from daily to three times weekly even for patients just entering treatment. Addicts find participation in treatment more acceptable and return more regularly, especially those trying to engage in work, education or rehabilitation activities outside the clinic. Some investigators also found that LAAM offers the patient a smoother, sustained drug effect. The patients appeared more alert and maintained a more stable emotional level. Oral consumption, even during the period of escalating doses, does not produce excessive sedation or subjective euphoria. This allows patients to function more effectively and lessens the possibility that LAAM itself will be abused. Large scale clinical tests of LAAM have been conducted and NIDA is seeking a commercial sponsor to complete development and market this drug.

Buprenorphine: It has been suggested that some individuals suffer from a deficiency in naturally occurring opiate-like chemicals (endorphins) and that some heroin addicts may be, in effect, making up for this deficiency by their use of heroin. Methadone and LAAM maintenance therapy for such individuals could be likened to the treatment of diabetes with insulin. It is also true that many individuals dependent on narcotics would like to be drug free. One of the major problems for such individuals is detoxification or withdrawal from the chemically dependent state. Buprenorphine is a member of a new class of drugs known as agonist/antagonists because in a chemical sense they both produce and block the effects of heroin. At lower levels, buprenorphine will elicit opiate-like effects; at higher levels the drug begins to reverse these same effects. Because its effect on respiratory depression is limited by its mode of action, buprenorphine is an extremely safe narcotic and appears to produce little physical dependence.

We have found the drug to show particular promise as a detoxification agent. Patients transferred from methadone to buprenorphine and maintained on the drug for several weeks show little if any withdrawal effects when the drug is terminated. NIDA is continuing to investigate the clinical significance of this drug for the treatment of opiate addiction.

Naltrexone: Naltrexone is a pure narcotic antagonist, i.e. it counteracts the effects of opiates, and is useful in a variety of treatment circumstances. For example, naltrexone has helped patients who have completed methadone detoxification or maintenance programs prevent readdiction. Also, individuals who have never been physically dependent but who are experimenting with heroin, and are therefore at risk of becoming physically dependent, may be suitable candidates for the administration of this non-addicting drug as an adjunct to other treatment services. A narcotic antagonist is an ideal pharmacological tool for these patients, especially since it does not produce physical dependence and can be taken over long periods of time or during periods of crisis. Among three narcotic antagonists studied clinically, naltrexone has emerged as the best.

Preclinical and clinical studies clearly demonstrate the efficacy of naltrexone as a narcotic antagonist. Two separate clinical trials, including random double blind studies, have produced convincing results indicating the therapeutic efficacy of naltrexone as an adjunct to the treatment of formerly narcotic dependent patients. Further, there does not appear to be any evidence of long-term toxicity associated with the administration of oral naltrexone. Patient compliance over time appears to be related to the provision of collateral services rather than any adverse effects of the drug. A depot (drug implant) preparation of naltrexone has also been developed that can deliver therapeutic doses of the drug for 30 days, which can possibly eliminate the need for daily drug taking. A new drug application (NDA) has been submitted to the FDA for naltrexone and approval is expected in FY 1984.

As described above it is expected that each of these new drugs will prove especially beneficial to discrete segments of the opiate abusing population, as well as to individual patients at different stages in the rehabilitative process. Important positive changes in the treatment delivery system can also be expected as these drugs become available, such as increased efficiency in program operations as well as diversification of treatment providers to include wider elements of the general health care system.

10. How does NIDA's research program address the need to develop treatment approaches that address the patient as a whole?

    o How much of NIDA's research budget is allocated to such research?

Treatment research supported by NIDA focuses not only on specific substances or specific behavior, but includes the social, psychological, and physiological problems and needs of the whole person. Seeking to understand how best to address these problems and needs, NIDA supports investigations of specific client groups where drug use is only one of many outcome measures. Other variables such as employment, self-esteem, and education, as they relate to drug abuse, are also considered. Multi-program studies examine the effects of various forms of treatment on different types of clients. In these studies, efforts are made to clarify elements of the treatment process, explore the nature, frequency, and intensity of services provided to clients and the nature of client and staff roles.

Natural history studies are conducted to better understand and characterize the complex events and influences experienced by drug abusers before, during, and after their periods of drug use.

Treatment research studies are being designed to evaluate psychodiagnostic and other strategies for classifying clients and exploring more appropriate means of matching client needs to various treatment services. In this regard, the question of "what treatment works best for what type of client" is a research priority.

NIDA also views treatment as a process that continues after clients leave formal/structured treatment programs. Research findings show that, to be successful over the long term, clients must develop new supportive relationships, make changes in their lifestyles, and gain access to basic community resources. Clients leaving treatment generally continue to need assistance in a number of specialized areas including; vocational counseling and job finding, family counseling, and developing positive social networks.

Treatment research, focusing on the above mentioned activities, is funded at approximately $6 million dollars in 1984. The Institute continues to test and evaluate many different treatment strategies that hold the promise of advancing the efficiency and effectiveness of drug abuse treatment services.

11. What type of research is NIDA conducting to measure the nature and extent of drug abuse among grade school, junior high, and younger age school students?

The National Household Survey includes persons aged 12 to 17 in its sample. As such, results of the National Survey can be generalized to the population of Americans in this age group. While the estimates provided by the National Survey are good indicators of drug use prevalence, and trends from year to year, they are by design not as specific as results that may emanate from a survey designed to study drug use among the younger age groups. Consequently, NIDA has proposed, in Fiscal Year 1986, to conduct a national survey of junior high school students which will complement prevalence estimates from the National Household Survey.

12. Regarding the Pyramid contract, renewed this year at a 65 percent reduction:
    - How will this loss of funding affect the level of services?
    - How will it affect NIDA's ability to provide national leadership?

Through consultation with national organizations and the private sector, the Institute uses existing resources more efficiently while ensuring continuation of NIDA's role in providing national leadership in the prevention area. The Institute's Prevention Branch has been able to respond to requests from both the public and private sectors directly, or through the Pyramid project.

Services previously provided through the Pyramid contract, such as the collection, screening, input and retrieval of prevention related information via a computerized system, have been assumed by NIDA staff. The Institute also has assumed responsibility for continued operation of a toll-free "800" telephone line previously provided through Pyramid.

In shifting these activities from the contractor to the Institute's Prevention Branch, neither the level or quality of prevention consultation services has been reduced. However, there has been a reduction in the number of on-site technical assistance days available from the Institute.

NIDA continues to be able to provide national leadership in the prevention area. Through workshops, conferences, and national meetings, NIDA provides consultation and disseminates monographs, prevention issue papers, and newsletters which deal with topics of national concern. In addition to sponsoring these activities, NIDA is frequently asked to help convene or provide technical assistance in the development of national conferences, publications, and national prevention programs sponsored by other groups.

13. Aside from Pyramid, what other technical assistance activities does NIDA conduct?

    o How has the ADMS Block Grant affected NIDA's technical assistance capabilities?

As described above, the Institute has refocused it's technical assistance activities to maximize use of existing resources. For example, NIDA provided assistance to the "Chemical People Project," the American Society for Industrial Security Conference, the National Association of State Alcohol and Drug Abuse Directors (NASADAD) Conference, and in the development and implementation of various national and regional drug abuse prevention media campaigns. Other technical assistance and program development consultation has been provided to such groups as Lion's International, the Boys Club of America, Peoples Drug Stores, and the National Broadcasting Company (NBC).

Prior to the funding of prevention services through the ADMS Block Grant program, NIDA's budget for prevention related technical assistance was considerably larger. The State Prevention Grant program was funded at approximately $8 million in 1981. These funds assisted the Institute in maintaining a close working relationship with the States and allowed NIDA some direct input into prevention programs developed by the States. While the ADMS Block Grant program has reduced the Institute's overall technical assistance capability, NIDA continues to provide limited and focused technical assistance services. A monthly newsletter has been developed and is disseminated to States, and NIDA staff have provided leadership in the development of a national prevention network designed to promote the exchange of information from the Federal Government and between the States and other groups.

NIDA's ability to provide on-site technical assistance in the treatment services area has been reduced. Nevertheless, technical assistance is still available which focuses on national organizations and large audiences, rather than on State agencies or individual treatment programs.

In the past year, two joint meetings have been held between NIDA (and NIAAA) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD). These meetings have become a major vehicle for providing technical assistance to States on a variety of treatment and service delivery issues.

In addition to the Technology Transfer Newsletter, NIDA maintains a close liaison with the private sector through such national organizations as: the American Medical Association; the American Academy for Child Psychiatry; the American Academy of Pediatrics; the American Psychological Association; the American Psychiatric Association; the United States Football League; the National Federation of Parents; and the Alcohol and Drug Abuse Problems Association. States and private sector organizations and corporations are encouraged to develop collaborative relationships with State medical organizations as a potential source of further technical assistance.

14. NIDA's budget for Research Training has fallen from $1,117,000 in 1981, to $973,000 in 1984, a drop of nearly 13 percent:

    o How has this reduction affected research training?

    o Is the amount available for 1984 adequate to attract enough new researchers to maintain a sufficient pool of qualified drug abuse researchers?

In Fiscal Year 1983, NIDA's budget for research training was $891,000. Because the budget authorization for NIDA's research training is under the continuing resolution, Congress funded the program for FY 1984 at the FY 1983 level of $891,000.

The Institute believes it is important to increase training of researchers in the United States through continued Federal support. The prospect for making significant advances in our understanding of addiction, dependence, and abuse directly hinges on our ability to pursue new areas of inquiry and to ensure the availability of high quality scientists. As experienced investigators leave drug abuse as a primary interest, their contribution in research and their ability to train able new investigators is either lost or delayed. Fluctuating funding levels result in a climate of uncertainty which is detrimental to national interests as researchers either leave the field or are required to devote increasing amounts of time to the pursuit of adequate resources.

15. Why has NIDA discontinued funding for clinical training?

    - Do you believe the lack of Federal support for clinical training is consistent with a need for strong Federal leadership in drug abuse prevention?

The clinical training program was instrumental in initiating drug abuse training in medical school and university curricula, in developing a pool of qualified drug abuse treatment personnel, and in assisting the States in improving their manpower development and management capabilities. The Institute's long-term clinical training goal has been to meet the Nation's drug abuse training needs by encouraging States to develop their own training programs through collaboration with academic and professional institutions and existing prevention and treatment service providers. The Federal role in achieving this goal was to provide technical assistance and financial support, largely through the National Training System (NTS). This strategy has allowed State officials, who are most aware of their own training needs, to assume a major role in determining the development of drug abuse training programs.

As a result, the Federal Government has gradually withdrawn from the direct delivery of training services while investing heavily in technical assistance and resource development. During this same period, there has been a corresponding emergence by the States as full collaborating partners, both in development of drug abuse training policy and in the delivery of training programs. For example, in 1971 NIDA bore approximately 90 percent of all costs associated with the training of drug abuse treatment workers. However, by 1979 the non-Federal share of all training-related costs had risen to approximately 50 percent as the States provided over 1,400 training programs to over 35,000 persons.

Given the substantial continuing efforts by the States, direct Federal support of clinical training activities was not seen as a high priority when evaluating competing needs for limited resources. Substantial training opportunities now exist that were not available ten years ago when NIDA first provided developmental training assistance. It is expected that the States will continue to rely on academic and professional institutions, as well as the service delivery system, for their clinical training needs as Federal resources are withdrawn.

16. Regarding substantial cuts in NIDA's publications budget:

- For each FY 1980-1984, provide budget amounts for these activities.
- How have budget cutbacks affected the National Clearinghouse For Drug Abuse Information (NCDAI) public information activities:
    - indicate the total volume of publications distributed by the Clearinghouse each year over the past 4 to 5 years
- How has NIDA policy changed with respect to the quantity of free publications available to groups and individuals?

- What steps has NIDA taken to get the GPO to establish a more reasonable price structure for NIDA publications?
- How successful have these efforts been?
- How much NIDA funding was dedicated to national media campaigns in 1983?
- Describe the media campaign in detail
- How much of NIDA's FY 1984 budget is to be used for media campaigns in 1984?
- Does NIDA have sufficient resources to provide effective national leadership in public education about drug abuse?

The Institute's public information activities have been significantly affected by two factors: the Office of Management and Budget directive to reduce the inventory of Federal publications, and NIDA's refocusing of public education efforts to support national prevention media campaigns. Both of these factors contribute to the overall reduction in the volume of publications available, although the potential audience for NIDA's prevention messages and materials has increased. Table 5 illustrates these trends.

Table 5

NIDA Printing And Public Affairs
Budget And Volume Of Publications -- 1980-1984

Year	Publications	Media Campaign	Number of Publications
1980	$ 1,100,000	- 0 -	3,214,263
1981	1,132,000	- 0 -	5,347,648
1982	508,000	$ 290,000	2,669,668
1983	556,000	8,000	2,518,911
1984	600,000	230,000	N/A

As total publication resources have declined, NIDA implemented a more conservative approach to distribution activities. Where NIDA had, prior to January 1981, provided up to 500 copies of certain publications to any group, bulk quantity limits were reduced to 200 copies per order. By June 1981, with existing supplies for some publications nearly exhausted and a printing "moratorium" in effect, the NCADI discontinued separate limits for groups and individuals and a maximum limit for any publication was established at 100 copies. The 100-copy limit has remained in effect for most of the prevention/education materials except for Parents, Peers and Pot and For Parents Only. Changes in the limit for these two publications went from 100 in June 1981, to 25 in February 1982, to 1 in May 1983. By August 1983, the supply of these two popular publications was exhausted and NIDA decided not to reprint these items so that a larger quantity of Parents, Peers and Pot II could be printed.

With respect to NIDA's efforts to secure more reasonable prices for publications available through the Government Printing Office (GPO), NIDA has had limited success. Prior to GPO's initiation of a new pricing formula in the Spring of 1983, NIDA negotiated special discount prices for bulk quantity orders. When the new pricing policy became effective, the GPO discontinued giving special bulk prices. However, NIDA has persuaded the GPO to sell "flyer" type publications in bulk quantities. As a result, the Peer Pressure flyer and Parents: What You Can Do About Drug Abuse are available for $8.00 and $14.00, respectively, per 100 copies. The GPO has also agreed to sell six new drug information flyers as a set in quantities of 100 for $9.50 per set.

As indicated above, the Institute has also refocused its public education activities to reach a broad national audience. In Fiscal Year 1982, NIDA developed two national media campaigns: the Marijuana Education Program and the National Drug Abuse Prevention Campaign. While the National Marijuana Education Program was implemented in FY 1983, the National Drug Abuse Prevention Campaign was designed to continue into FY 1984 as well. Also in FY 1983, the Institute assisted the National Broadcasting Company in developing a media campaign involving its five owned-and-operated stations and its 200 affiliates. This program, called "Don't be a Dope," featured NBC television stars who presented messages about peer pressure that NIDA research has found effective in preventing drug abuse. In addition, NIDA assisted Peoples Drug Stores in developing the concepts and pamphlets in its "Drug Abuse:" Spot It/Stop It" program that included many of the themes for parents also being promoted in the National Drug Abuse Prevention Campaign developed by the Advertising Council.

The National Drug Abuse Prevention Campaign is designed to reach parents and young people with drug abuse prevention messages through a broad range of media materials. The campaign is designed to motivate parents to learn about drugs, talk to their children about the drug problem, and join with other parents to discourage drug abuse in their community. Building on NIDA research findings that teens do respond to concerns about the health consequences of drugs, NIDA is seeking to motivate young people to take appropriate action to resist peer pressure without losing status among their friends. These themes and approaches were integrated into the campaign by the advertising agency, Needham, Harper & Steers, which volunteered under the auspices of the Advertising Council. The Institute worked with the advertising agency to develop a campaign which addresses young people, age 12 to 14, and parents of children aged 9 to 18 who may be about to face drug use by their children, or are already confronted with the problem and are unsure of what to do about it. The two programs are designed to reinforce each other. After the advertising agency reviewed the literature on the target audience, they developed a creative strategy for young people designed to:

- prevent the first use of drugs;
- suggest that use of drugs is not essential to peer acceptance;
- point out that not everyone uses drugs; and
- communicate current factual information about drug abuse.

The main theme of the campaign is communicated and reinforced through print ads, posters, and radio and television messages which focus on the slogan, "Just Say No."

The creative strategy for parents includes the following:

- convince parents to involve themselves early in drug abuse prevention efforts;
- motivate parents by providing advice and guidance on how to become involved;
- alert parents to the signs and symptoms of drug abuse;
- create an atmosphere of open communication between parents and their children;
- establish family rules about drug use; and
- become involved with other parents to draw on mutual experiences and develop mutual support.

Through print ads and radio and television public service announcements, the major message for parents, "Get Involved With Drugs Before Your Children Do," is communicated.

Broadcast materials for the campaign were distributed by the Advertising Council to commercial radio and television stations throughout the Nation and are currently being broadcast as public service announcements.

Continuation of the Drug Abuse Prevention Media Campaign in Fiscal Years 1984 and 1985 will reinforce the parent and youth themes for the general audience. Also, these themes will be incorporated into appropriate materials for special target audiences including Black and Hispanic youngsters.

Despite more limited resources, NIDA has produced media campaigns, encouraged other national organizations to promote important prevention messages, and continued to develop and print numerous publications. Through these activities the Institute provides effective national leadership to public education efforts in the drug abuse field.

17. Regarding treatment effectiveness studies:

    o If treatment is so effective in reducing social costs of drug abuse, why doesn't the Federal Government spend more on treatment instead of cutting funds under the ADMS Block Grant program?

Although federal funding through the ADMS Block Grant program continues to represent a substantial portion of total revenues available to support drug abuse prevention and treatment services, the Federal Government has never been the major direct supporter of drug abuse treatment and prevention services. State and local governments, other public welfare programs, public and private insurance, and client fees have always made up the bulk of total funding. In the period between 1977 and 1980, when the Federal Government's funding for drug abuse services was at its highest level, it amounted to only between 33 and 38 percent respectively of the total funds available. For this reason, it is somewhat misleading to view reductions under the ADMS Block Grant program as equivalent reductions in overall funding levels.

The following information was taken from results of the National Drug and Alcohol Treatment Utilization Survey in 1980 and 1982.

Table 6

Revenue Reported By Funding Source
(Dollars in Thousands)

SOURCE	1980	1982	DIFFERENCE	PCT. CHANGE
Federal Grants	187,065	125,446	(61,619)	(33%)
State and Local Gov't	159,094	223,447	64,353	40%
Third Party Payments	95,358	128,142	32,784	34%
Client Fees	21,338	35,588	14,250	67%
Private Donations	17,360	17,358	(2)	-0-
Other	6,368	3,651	(2,717)	(43%)
Totals:	486,583	533,632	47,049	10%

The available evidence indicates that more money was available for drug abuse prevention and treatment services in 1982 than in any earlier year. While this may in part reflect carryover funds unspent from previous Federal grant programs, the data also suggest that funds provided by State and local governments, third-party payors, and client fees increased between 1980 and 1982 resulting in a net gain of 10 percent.

As far as treatment effectiveness studies are concerned, it is true that on three major outcome criteria --drug use, criminal activity, and employment status-- clients in drug abuse treatment programs experience significant improvement.

Several large-scale studies have evaluated the effectiveness of drug abuse treatment services with large groups of patients and in many different treatment programs. The Drug Abuse Reporting Process (DARP) studied 44,000 clients admitted to 52 programs between 1969 and 1974. Follow-up data collected on about 10 percent of these patients, an average of four years after discharge, provided an indication of how successful treatment had been for these clients. More recently, the Treatment Outcome Prospective Study (TOPS) followed 11,750 clients in 41 treatment programs scattered throughout the United States. A third large-scale study evaluated the effectiveness of 49 Veterans Administration drug dependence treatment programs using a sample of 1,655 patients. All of these multi-program studies had a similar design in that they represented unbiased evaluations of patients before, during and after treatment by independent evaluators. The results of these studies were strikingly similar. Findings from each study showed substantial client improvement in social functioning and employment, as well as major reductions in drug use and criminality after treatment. These results were found consistently among patients treated in methadone maintenance, residential and outpatient drug-free modalities. Those who dropped out of treatment early showed little or no improvement, while patients who stayed in treatment longer showed more improvement.

These findings, coupled with data suggesting that total financial resources have not declined between 1980 and 1982, indicate that effective treatment services for drug abusers continue to be available nationwide. In addition, as States gain more experience in managing their ADM service system it is likely that treatment services at the local level will be better able to serve clients with multiple ADM problems.

18. How has the shift to the ADMS Block Grant program affected NIDA's relationship with State and local drug abuse agencies?

    o How has it affected information exchange?

    o Please comment on concern expressed by State and local treatment providers that NIDA is too removed from the treatment service system.

Consolidation of Federal funding for drug abuse services into the ADMS Block Grant program affected NIDA's relationship with the States chiefly in that the Institute no longer monitors use of the funds. Actually, since 1974 NIDA had gradually shifted responsibility for management of federally funded services to State agencies. By 1979, monitoring of local service providers was almost exclusively the responsibility of each State, with NIDA's role limited to overall management of Federal grants and providing technical assistance upon request.

Consequently, NIDA's relationship with the States has changed very little, as the ADMS Block Grant program represents a natural step in placing authority for services in the hands of State officials most capable of allocating resources according to local priorities. Similarly, the Institute's relationship with local prevention and treatment service providers has changed very little since NIDA had discontinued direct funding of local services long before 1981.

Throughout the 1970s, as NIDA gradually withdrew it's direct management involvement in service-related programs, the Institute developed effective means of information exchange with States and local service providers. Technical assistance programs were emphasized and provided needed clinical and management information to States and their service,providers. Research findings applicable to the drug abuse treatment community were regularly prepared by NIDA and disseminated to the field. Other publications were, and continue to be, available through the NCDAI. At national meetings, often sponsored in conjunction with national associations concerned with drug abuse, the exchange of information and discussion of issues often benefited both NIDA and the States.

With the exception of NIDA's service-related technical assistance capability, the Institute has maintained most elements of its information exchange program. Since 1981, increased emphasis has been placed on developing and disseminating research findings. The NCDAI has continued to provide substantial information services, although it has been unable to keep pace with increased demand for publications. National meetings specific to the drug abuse service system continue, and NIDA has increased efforts to provide information to the private sector.

Through these activities, the Institute has continued its relationship with State and local service providers. In addition, NIDA continues to: provide research support to some agencies also operating treatment services; collect voluntarily-supplied program and client information and produce analytic reports; and, provide limited technical assistance to States on clinical and management related matters.

19. What evidence do we have to support the contention that there may be an increase in the level of use and danger of the pattern of use of cocaine despite the fact that overall use is down?

Health related consequences associated with cocaine use have continued to rise since 1981. In fact, since 1976 nearly all metropolitan areas have reported substantial increases in cocaine related emergencies and treatment admissions. Although complete death data are not yet available, emergency room mentions increased 15 percent between 1980 and 1981. In addition, treatment admission data for the period 1977-1981 showed that there has been a shift from nasal use of the drug to more dangerous forms of administration, such as intravenous use and "free-basing" or smoking cocaine. Free-basing has risen from 0.9 percent in 1977 to 4.7 percent in 1981, while intravenous use has increased from 24.6 percent in 1977 to 29.7 percent in 1981. Intravenous use of cocaine has also increased in DAWN emergency room data since 1978, rising from 27 percent to 41 percent in 1982. Table 7 charts the changing trends in the route of administration of cocaine as reported by clients admitted to treatment programs.

Table 7

Percent Distribution of Primary Cocaine Admissions
By Route Of Administration
1977 -- 1981

Route of Administration	1977	1978	1979	1980	1981
Inhalation/Nasal	68.6	69.1	66.7	61.2	60.3
Smoking Free Base	0.9	0.9	1.0	2.4	4.7
Intravenous	24.6	25.5	26.9	31.3	29.7
Other	5.9	4.6	5.5	5.1	5.3
Percent Total	100.0	100.0	100.0	100.0	100.0
Number of Clients	3,382	5,894	8,997	11,325	14,208

Smoking and intravenous use of cocaine leads to more frequent and compulsive use of the drug as evidenced by Table 8, which indicates that approximately 26 percent of individuals using the drug nasally report daily use, while over 45 percent of individuals engaged in either smoking or intravenous use of cocaine report daily use patterns prior to entering treatment.

Table 8

Percent Distribution of Primary Cocaine Admissions
By Frequency of Use and Route of Administration -- 1981

	Route of Administration		
Frequency of Use	Inhalation/Nasal	Intravenous	Smoking
Once a week or less	48.3	30.8	27.8
Several times a week	25.5	22.4	26.6
Daily	26.2	46.8	45.6
Percent Total	100.0	100.0	100.0
Number of Clients	8,646	4,243	668

In 1979, it was estimated that as many as 10 million people had tried cocaine at least once in the past year. Data from the 1982 National Survey, however, suggests that the total number of Americans using cocaine may be stabilizing. In the High School Senior Survey, both the perceived availability of cocaine and the prevalence of use among the seniors surveyed has stabilized since 1979.

These estimates along with health consequence data from treatment programs and hospitals suggest that although overall cocaine use may be stabilizing, an increasing segment of the using population may be engaged in more serious abuse patterns.

20. Please provide information about the effect of possible distortion in the High School Senior and National Household surveys if other high using groups were included in the samples of these national surveys?

These two national surveys form the basis for periodic estimates of the incidence and prevalence of drug abuse in the United States, as well as for assessing trends in drug use over time. When reviewing the results of these surveys, there is an understandable tendency to generalize the findings to all youth of high school age or to all Americans. Because each survey is designed to measure use within a specific population, generalizing the findings to the entire population is not possible. As outlined in our answer to question number 5 (see page 8) the samples for these two national surveys do not include small groups of persons known to have high drug use patterns. For instance, persons not residing in a household are excluded from the National Survey. Similarily, in the High School Senior Survey only seniors present on the day the questionnaires are administered are included in the sample. To study the effect of these exclusions, NIDA convened a Technical Review in 1982 to examine the impact of this sampling exclusion in the High School survey and to produce adjusted estimates to compensate for the exclusion.

The Technical Review concluded that the observed prevalence of cigarette and marijuana use was understated in the high school survey by about 2 percent to 4 percent, and from 5 to 7 percent, respectively. While these understatements may impact the absolute size of estimates each year, they have little or no effect on assessing trends in drug use over time. The shape and slope of the trend lines in drug use will remain the same since it is assumed the same level of distortion exists each year. Elsewhere (see page 9) Table 1 presents estimates of drug use for selected substances among a combined population of seniors, absentees and dropouts.

As shown there, even though drug use may be considerably higher among absentees and dropouts, a high level of use within a comparatively small proportion of the general population has little influence on the overall estimates derived from the study of high school seniors. In addition, trends from year-to-year are not affected since the adjustments for unsampled groups are likely to remain consistent from one year to the next.

CITY OF PHILADELPHIA

DEPARTMENT OF PUBLIC HEALTH
COORDINATING OFFICE FOR
DRUG AND ALCOHOL ABUSE PROGRAMS
841 Chestnut Street, Philadelphia, PA. 19107
Third Floor

STUART H. SHAPIRO, M.D., M.P.H.
Health Commissioner

NICHOLAS L. PICCONE, Ed. D.,
Executive Director

November 16, 1983

The Honorable Charles B. Rangel
Chairman
U.S. House of Representatives
Select Committee on Narcotics
Abuse and Control
Room H2-234, House Office Building Annex 2
Washington, D.C. 20515

Dear Mr. Rangel:

It was most gratifying to have had the opportunity to present testimony, along with my colleagues from Boston and the District of Columbia, before the House Select Committee on Narcotic Abuse and Control. As you are now well aware, all urban areas are currently experiencing increasing demands for drug treatment services in the face of decreasing funding support and a problematic bureaucratic structure created by the Federal Block Grant process.

In response to your specific request, I am forwarding correspondence between the City of Philadelphia D & A Program and the State. The several questions asked of the panel of city representatives included one which concerned the degree of participation we had with our respective state agencies in developing the strategy for ADM block reductions. The members of the Select Committee seemed incredulous when I responded that indeed no opportunity had occured that allowed for any participation from our office. The State Office of Drug and Alcohol Programs did establish a Block Grant Advisory Task Force in the spring. The city agency responsible for managing the D & A system in Philadelphia, however, was excluded from the Task Force's activities.

When I asked the State Agency Director why we were not included in the Task Force membership, I was told that a list of names had been submitted to the Governor and mine had not been selected. This response prompted a letter of protest from the Chairman of the Mayor's Drug and Alcohol Commission. In the absence of a response to that letter of June 27, 1983, I wrote again on August 18th outlining the significant problems Philadelphia would suffer if the state's proposed plan for FY'85 is implemented. I also referenced our exclusion from the Federal Block Advisory Committee and asked to meet with state representatives at their convenience. This request has thus far been ignored.

It is important to note that there were nine members of the task force. There were two from Pittsburgh and only one from Philadelphia, even though the Philadelphia D & A system is more than twice the size of Pittsburgh's, which is the second largest system in the Commonwealth. Furthermore, the Philadelphia representative, the director of a private prevention program, is not familiar with nor interfaces with the total D & A system.

I did receive a response dated September 20, 1983 to my second letter. This response merely affirmed the state's position and did not address our request for direct negotiation. The Chairman of the Mayor's Drug and Alcohol Commission replied on October 14th again protesting the effects of the state's Block Grant allocation process on the County of Philadelphia and reiterating our need to serve on those committees participating in the funding process. As you know, the current state funding plan will mean a $2,000,000 loss to Philadelphia. To date, our efforts have been unsuccessful.

As you will note from the correspondence and from my testimony to the Select Committee, although Philadelphia has the largest D & A system in the state and is slated to receive the largest funding cutback, no attempt was made to bring us into the planning process for allocation of the Block Grant. In fact, there is every indication that we were deliberately excluded from this process. As also emphasized in this documentation, the state did not make funding decisions based on need, a logical approach, but instead based their decisions on a per capita formula which we believe was politically biased against urban communities.

Large Eastern seaboard cities traditionally present difficulties to state governments which, by their very nature, represent larger areas of rural and suburban kinds of communities. They tend to overlook the diversity of population and consequent need for a multiplicity of services which are required by urban residents. It is for these reasons that we so strongly recommend direct federal funding to the nation's largest cities or in lieu of that, a federal mandate that Block Grant funds be distributed solely on the basis of documented need.

Hopefully, the information regarding our exclusion from the State's Block Grant Task Force activities will prompt your committee to develop safeguards so that large urban centers are indeed meaningfully involved in the development of allocation/cutback strategies.

I want to thank you again for your interest in these issues and for the opportunity to share our views and experience with you.

Sincerely yours,

Nicholas L. Piccone, Ed.D.
Executive Director

NLP:tb

cc: Stuart H. Shapiro, M.D., M.P.H., Health Commissioner
Bettina Hoerlin, Ph.D., Deputy Health Commissioner
Joseph Glancy, Chairman, Mayor's Drug and Alcohol Exeuctive Commission

CITY OF PHILADELPHIA
WILLIAM J. GREEN, Mayor

MAYOR'S DRUG AND
ALCOHOL EXECUTIVE
COMMISSION
841 Chestnut Street, 3rd Floor
Philadelphia, PA 19107

HONORABLE JOSEPH GLANCEY, Chairman
PASCAL SCOLES, D.S.W., Vice Chairman
ERIC WARD, Secretary
NICHOLAS L. PICCONE, Ed. D., Executive Director

June 27, 1983

Ms. Lucedille Fleming, Deputy Secretary
Department of Health
Office of Drug and Alcohol Programs
Room 809
P.O. Box 90
Harrisburg, PA 17120

Dear Ms. Fleming:

As Chairman of the Mayor's Drug and Alcohol Executive Commission of Philadelphia, I am writing to comment on the Commission's concerns regarding ODAP's past, present and future policies affecting our City's Drug and Alcohol Abuse Service System.

The Commission believes that CODAAP has worked unceasingly to procure the best service for Philadelphia's drug and alcohol abuse clients through a balanced, comprehensive and cost effective service delivery system. If we are to continue to do this, we need the support of all levels of government through the Federal-State funding process. It is therefore disconcerting and discouraging to review ODAP's membership list regarding the Drug and Alcohol Task Force and determine that CODAAP has been excluded from representation.

It is incredulous to us that the membership of the D & A Block Grant Task Force does not include the Executive Director of CODAAP since Philadelphia has suffered, by far, the greatest loss of Federal funds in the State.

While we note the appropriate presence of Sr. Madeleine Boyd on the Task Force membership list, you are certainly aware that she will be representing primarily prevention interests and should not be expected to have a systems perspective of the SCA. We believe that the omission of CODAAP's Executive Director from the Task Force is another example of ODAP's insensitivity toward Philadelphia's needs. This pattern is in conflict with the Block Grant regulations which specify needs-based criteria that do not jeopardize existing programs.

While we appreciate that State funds have been appropriated to offset some of the loss of Federal funds, we can't understand why ODAP, again, uses only a portion of these funds for the purpose of replacing block dollars to the City.

The Mayor's Drug and Alcohol Executive Commission would appreciate your review of our concerns.

Sincerely,

Judge Joseph R. Glancey
Chairman

JRG:tc

cc: Nicholas L. Piccone, Executive Director
Legislative Delegation

DEPARTMENT OF PUBLIC HEALTH
COORDINATING OFFICE FOR
DRUG AND ALCOHOL ABUSE PROGRAMS
841 Chestnut Street, Philadelphia, PA. 19107
Third Floor
STUART H. SHAPIRO, M.D., M.P.H.
Health Commissioner
NICHOLAS L. PICCONE, Ed. D.,
Executive Director

CITY OF PHILADELPHIA

August 18, 1983

Luceille Fleming, Deputy Secretary
Department of Health
Office of Drug and Alcohol Programs
P.O. Box 90, Room 809
Harrisburg, Pa. 17120

Dear Ms. Fleming:

After due consideration of the implications regarding your recent notice to CODAAP of an additional 25% cut in our FY'85 Federal Treatment Block allocation, we feel it necessary to communicate our deep concern. As you are aware, an additional 25% cut in our Federal Treatment Block allocation will mean a 40% loss of federal support from FY'81 through FY'85 ... approximately $2,760,800. The spectre for the future is so real that one must reflect on the past for a perspective before one becomes totally dismayed. The ODAP decision-making process has played havoc with our programming. I offer, by example, the following sequence of events and their impact on our prevention funding (see Table A attached). In FY'82, Philadelphia Federal funding for prevention services was equal to 12.8% of the prevention Federal money received by ODAP. In FY'83, Philadelphia received only 4.2% of ODAP Federal prevention funds. It was further reduced to 3.3% in the present fiscal year ('84). Reductions of this nature are unfair and in conflict with the intent of the Federal Block legislation because they have resulted in service loss. The State could have met the new Federal prevention requirement by allowing Philadelphia to reprogram the Federal allocation dedicated to the City and its programs. However, ODAP choose to distribute the prevention allocation (which came largely from Philadelphia treatment funds) by a new formula. We, therefore, are troubled by a 63% loss in Federal prevention funds from FY'81 to FY'84 ($142,025). As you are also aware, CODAAP treatment programs suffered additional cuts in FY'84. In human terms services to approximately 1,000 clients were lost through these severe cutbacks. It was only through very creative management techniques and hard work that Philadelphia has maintained an array of services reasonably responsive to the community's needs. Most (90%) of our programs are presently over-utilized as you can readily determine from the UDCS reports (see attachment B; June, 1983 UDCS Utilization Report).

The spectre for the upcoming fiscal year ('85) is outlined in your notice to CODAAP requiring our planning for an additional 25% loss in Federal Block support. This 25% cut ($1,469,300) added to previous cuts amounts to an overall cut in originally allocated dollars of 40% ($2,760,800) through FY'85. When the other revenue that is generated by the provision of these services is added to the Federal cutback schedule the true dollar loss approaches $2 million in FY'85 alone. An example of this revenue loss as translated into human terms would be the elimination of 53,815 units of alcoholism treatment service for 4,770 clients in OPDF, residential detox, residential and emergency care services. This, of course, would leave Philadelphia without any Public Inebriate services. The cuts would further deprive 1,450 clients of 25,395 units of drug treatment service in inpatient detox, and four OPDF programs, one dispensing methadone and one treating youthful polydrug abusers.

The pending State allocation cutbacks as presented above are unacceptable at best. We need additional support for our over-utilized programs - not less. We have been our own worst enemies during the recent cutbacks by continuing to fill service gaps in creative ways. It appears as though we can do with less. Well, it just isn't so for FY'85. We are going to lose our service capacity across the board as graphically displayed by the example given above.

An additional concern to ODAP should be the loss of those Philadelphia based services to other counties presently accessing them. With no place for the almost 300 out-of-county clients we serve at any given time to access services, an additional burden will be placed on the county-of-origin. Even if the county-of-origin had the resources to start-up new services, the political implications for establishing methadone maintenance programs is delicate at best (see attachment C). Our present policy of 90/10 in-county/out-of-county residents will be changed if no increase in our service allocation is made.

It is then our opinion that drug and alcohol services in the Southeastern Region will collapse within the next several years. The beginning of the collapse is as near as the FY'85 cutback. The scheduled cutback must be stopped. The City/County of Philadelphia must not be continually victimized by ODAP policy as cited earlier in this correspondence.

The recent exclusion from the Federal Block Advisory Committee as attested to in Judge Glancey's letter of 6/27/83, has not been viewed as a positive act on ODAP's part. This office does, however, stand ready to meet with ODAP representatives at any time - the sooner the better - to discuss actions we can take together to offset this pending disaster in an important area of human services.

These are bad times, but the future appears to be even more desperate - we, however, continue to have hope - I am the eternal optimist, as you know. We would like to know what your plans are for reducing the cutback levels, if not eliminating them altogether.

Sincerely,

Nicholas L. Piccone, Ed.D.
Executive Director

NLP:er
Attachments
cc: D&A Directors
NACDAC
PACDAA
GAO Regional Office
A. Muller, M.D., Secretary of Health
S. H. Shapiro, M.D., M.P.H., Health Commissioner
B. Hoerlin, Ph.D., Deputy Health Commissioner
Mayor's Commission
Forum
Alliance

ATTACHMENT A

FEDERAL PREVENTION FUNDS

	FY'81	FY'82	FY'83	FY'84
CODAAP Philadelphia				
Block Funds	-	-	113,510	82,200
Direct Institute Grants	206,225	76,000	-	-
ODAP	18,000	24,000	-	-
Total Federal Funds	224,225	100,000	113,510	82,200
% of FY'81 Federal Funds	100%	44.6%	50.6%	36.7%
ODAP				
Federal Total Funds	-	780,000	2,685,000	2,497,000
CODAAP % of Total Federal Funds Received by ODAP	-	12.8%	4.2%	3.3%
Block Funds for Services				
SCA's	-	14,000	1,519,000	1,658,600
Statewide	-	93,000	927,000	526,000
Total	-	107,000	2,446,000	2,184,600
CODAAP % of Total State Block Funds Allocated for Services		0%	4.6%	3.8%

ATTACHMENT B

CODAAP - CITY OF PHILADELPHIA - JUNE 1983 (from UDCS Report)

FACILITY UTILIZATION RATES FOR JUNE, 1983.

IF A FACILITY IS NOT INCLUDED, IT WAS OUT OF COMPLIANCE FOR THE REPORT MONTH.

FACILITY NAME	A/A	AWARD LETTER CAPACITY	I S TOTAL CLIENTS	UTIL RATE
ACHIEVEMENT THRU COUNSELING & TREATMENT	862	374	433	115.8
	863	117	196	167.5
AL ASSIST/DWI REFERRAL PROG	863	75	52	69.3
ALCOHOL AND MENTAL HEALTH ASSOCS	862	55	85	154.5
	863	250	189	75.6
ALCOHOLISM COUNSELING & RECOVERY PROG	863	100	173	173.0
BRIDGE - THERAPEUTIC CENTER AT FOX CHASE	823	54	58	107.4
BRIDGE ADOLESCENT POLYDRUG PROGRAM	863	34	51	150.0
CENTRO DE SERVICIOS PARA HISPANOS	863	46	44	95.7
COMP MH/MR PROG DRUG FREE UNIT	863	62	74	119.4
COMP MH/MR PROG METH CLINIC	862	112	123	109.8
COMPREHENSIVE MH/MR DWI PROG	863	135	146	108.1
CONGRESO DE LATINOS UNIDOS	863	130	128	98.5
CORA SERVICES	863	75	75	100.0
CORPORATION OF VERITAS REGAN HOUSE	873	22	32	100.0
DRC INTERMEDIATE RESIDENCE	823	25	26	104.0
DRC MAIN	863	310	396	127.7
DRC RESIDENTIAL DETOX	821	21	24	114.3
FAMILY CTR PROG OF THOS JEFFERSON UNIV	862	40	53	132.5
	863	5	11	220.0
GAUDENZIA HOUSE TIOGA	823	37	35	94.6
GAUDENZIA OUTREACH	863	130	135	103.8
GAUDENZIA WEST CHESTER	823	40	46	115.0
GENESIS II INC	823	40	38	95.0

ATTACHMENT F

FACILITY UTILIZATION RATES FOR JUNE, 1983.

IF A FACILITY IS NOT INCLUDED, IT WAS OUT OF COMPLIANCE FOR THE REPORT MONTH.

FACILITY NAME	A/A	AWARD LETTER CAPACITY	F S TOTAL CLIENTS	UTIL RATE
GENESIS II, INC.	863	12	17	141.7
GIUFFRE - C. DUDLEY SAUL CLINIC	831	54	50	92.6
GIUFFRE - HELEN L. GOLDMAN REHAB CLINIC	862	231	394	170.6
	863	5	12	240.0
GIUFFRE COMPREHENSIVE ALCOHOLISM PROG	863	175	213	121.7
GIUFFRE INPATIENT DRUG UNIT	831	26	23	88.5
GIUFFRE MALE ALCOHOLIC RESIDENCE	823	20	18	90.0
HELP INC	863	60	57	95.0
HORIZON HOUSE DRUG REHAB PROG.	823	32	36	112.5
HORIZON HOUSE OUTPATIENT PROG.	863	57	79	138.6
IMPACT SERVICES, INC.	855	20	5	25.0
INTERCOMMUNITY ACTION INC	863	50	40	80.0
INTERIM HOUSE INC	823	21	20	95.2
J F KENNEDY CMH/MR DRUG TREATMENT CTR	862	228	295	125.4
	863	7	14	200.0
J F KENNEDY CMH/MR LUDLOW ACCEPTANCE C	863	5	5	100.0
J F KENNEDY CMH/MR WALK-IN CLINIC	863	16	38	237.5
JEFFERSON OUTREACH D/A CENTRAL DST	863	44	82	186.4
JEFFERSON OUTREACH D/A SOUTHERN DST	863	25	37	148.0
LKEC SOLVENT ABUSE PROJECT	863	34	31	91.2
LOWER KENSINGTON CRISIS CENTER	863	77	111	144.2
LOWER KENSINGTON ENV CTR YOUTH-ALC PRO	863	80	75	93.8
LOWER KENSINGTON ENVIRONMENTAL CENTER	823	30	33	110.0
LOWER KENSINGTON ENVIRONMENTAL CTR	823	25	28	112.0

ATTACHMENT B (3)

FACILITY UTILIZATION RATES FOR JUNE, 1983.

IF A FACILITY IS NOT INCLUDED, IT WAS OUT OF COMPLIANCE FOR THE REPORT MONTH.

FACILITY NAME	A/A	AWARD LETTER CAPACITY	F S TOTAL CLIENTS	UTIL RATE
MANTUA HUMAN SERVICES	862	117	227	194.0
	863	3	23	766.7
NARCOTIC ADDIC REHAB PROGRAM OF TJU	862	403	299	74.2
NORTHWEST CENTER	863	75	107	142.7
PATH INCORPORATED	863	125	129	103.2
PPC METHADONE PROGRAM	862	275	340	123.6
PPC NEW DIRECTIONS HOUSE	863	89	93	104.5
PPC WESTMINSTER CLINIC	863	94	108	114.9
PPC WURZEL CLINIC	831	9	12	133.3
	863	115	146	127.0
PPCDTP ADOLESCENT POLYDRUG PROG.	863	30	41	136.7
SELF HELP MOVEMENT, INC.	823	20	24	120.0
ST JOSEPH'S HOSPITAL ALC CLINIC	863	13	54	415.4
THE ALCOHOLISM FOUNDATION INC.	863	65	233	358.5
WP - HIGHWAY SAFETY TREAT PROG	863	60	29	48.3
WP - SOUTHWEST COUNSELING CENTER	863	86	145	168.6
WP - UNIV CITY ALCOHOLISM OP CTR	863	15	77	513.3
WP-LARCH/COBBS CRK	863	71	80	112.7
WP-METHADONE SERVICE	861	20	17	85.0
	862	216	197	62.3
WPCMH CONSORTIUM INC FOUR	863	30	45	150.0

ATTACHMENT C

MEMORANDUM

[illegible]

DATE [illegible]

O : Nicholas L. Piccone, Ed.D., Director

ROM : Mark Benelvengo, Deputy Director MB

UBJECT: OUT-OF-COUNTY INFORMATION

Out-of-County Information. Number of clients currently in treatment originating outside of Philadelphia.

1. Bridge Residence 14 + 9 out-of-State
2. Bridge Family & Youth 8
3. Bridge Polydrug 1 out-of-State
4. DRC 0
5. LKEC YAP 0
6. ACT 42 approximately
7. PATH 2% approximately (all from Bucks)
8. Horizon House 0 Program will not accept out-of-County
9. West Phila. Alcohol 2
10. Highway Safety 1
11. West Phila. Methadone 31 + 16 out-of-State
12. Comprehensive MM 2
13. Comprehensive Alcohol 0
14. Veritas 0
15. Northwest 1
16. PPC New Directions 0
17. PPC M Clinic 20 + 2 out-of-State
18. PPC Westminster 0
19. Wurzel 12 + 1 out-of-state
20. CORA 10
21. Congreso 0
22. Genesis II Residence 3 + 5 out-of-state
23. Genesis II Outpatient 0
24. Interac 0
25. SPHA 0
26. Giuffre CAP 0
27. Giuffre Impatient Drug 0
28. Giuffre saul 0
29. Giuffre Goldman 10 + 4 out-of-state
30. Giuffre Residence 3
31. AMHA 1 + 1 out-of-state
32. Interim House 2
33. Friendship 1 out-of-state
34. Self-Help 4 + 1 out-of-state
35. NCA 3 - 4% of clients coming in for evaluation
36. Mantua 14
37. Help 3 + 2 out-of-state
38. Jefferson Family Center 3
39. Jefferson Southern 0
40. Jefferson Central 2 + 1 out-of-state
41. Jefferson NARP 9 + 11 out-of-state
42. Gaudenzia West Chester 15 out of 40
43. Gaudenzia Tioga 13 out of 31
44. Gaudenzia Outreach 3
45. JFK Walk-in 3 + 1 out-of-state
46. JFK Methadone 15 + 3 out-of-state

Commonwealth of Pennsylvania

DEPARTMENT OF HEALTH

DEPUTY SECRETARY
Office of Drug and Alcohol Programs

September 20, 1983

Nicholas Piccone, Ed.D.
Executive Director
Coordinating Office for Drug and
  Alcohol Abuse Programs
841 Chestnut Street, Third Floor
Philadelphia, PA 19107

Dear Dr. Piccone:

This is in response to your recent letter in which you cite the anticipated loss of services in Philadelphia that will occur in 1984-85 due to the 25% reduction in Federal Block Grant Treatment dollars.

I must first commend your ability to calculate so precisely the services and clients which will be impacted by the reduction. I would also commend the results you have achieved to date in maintaining a need responsive system despite cutbacks received in the last two years.

However, I must take issue with the manner in which you present the seeming causes of the problem in relating it primarily to ODAP policy.

At the time of transition to Block Grants in 1981 it was clearly stated in Federal legislation that there would ultimately be a funding reduction to 75% of 1980-81 levels. Further, that only certain types of Federal grants were considered to be part of the base for which the states' block grant allocation would be calculated. To condense what we have many times explained in previous announcements, discussion sessions, plan guidelines, correspondence, etc. we would carry forward funding commitment levels as long as we could in order to give the SCA's time to plan for the certain eventuality that they would be reduced to the level now anticipated for 1984-85.

The earmarking of 20% of the total available Federal dollars for Prevention/Intervention despite the prevailing Federal funding level of less than

10% was a decision written into law by Congress and was not a policy of ODAP. The additional funding needed to meet this percentage request did indeed have to come from the amount that was at that time allocated for treatment. There was simply no alternative.

In addition, the single major prevention grant received by a Philadelphia program (roughly $206,000 for Shalom) was considered ineligible for continuation under the Block Grant allocation because it terminated at the time of transition according to Federal records. This single fact alone, if properly reflected in your data would therefore show that you received an increase due to the ODAP funding policy for the allocation of the Federal Prevention/Intervention funds.

I must reaffirm that our policies reflect a concern for a fair statewide allocation of funds coupled with a concern that prevailing commitment levels be maintained as much as possible. The Federal grant funding system never looked at Philadelphia as an entity in their direct grant system - we do. We have less dollars under the present outlook but have given you much greater flexibility and latitude in allocating them where most needed.

If we receive additional Federal or State funds we will continue to allocate from the policy point of meeting the same basic concerns and believe we have been quite fair to Philadelphia.

We will do what we can to request funding levels to meet determined service needs; however, we must simultaneously focus efforts on what action must be taken to face the currently anticipated level for 1984-85. To that end I would offer any assistance ODAP can provide and I again commend you on being able to calculate so well the relationship between dollars and services so that you can implement appropriate funding strategies.

Cordially,

Lucille Fleming

Lucille Fleming
Deputy Secretary for Drug and
Alcohol Programs
Department of Health

CITY OF PHILADELPHIA
WILLIAM J. GREEN, Mayor

MAYOR'S DRUG AND
ALCOHOL EXECUTIVE
COMMISSION
841 Chestnut Street, 3rd Floor
Philadelphia, PA 19107

HONORABLE JOSEPH GLANCEY, Chairman
PASCAL SCOLES, D.S.W., Vice Chairman
ERIC WARD, Secretary
NICHOLAS L. PICCONE, Ed. D., Executive Director

October 14, 1983

Luceille Fleming, Deputy Secretary
Department of Health
Office of Drug and Alcohol Programs
P. O. Box 90, Room 809
Harrisburg, PA. 17120

Dear Ms. Fleming:

We were very disappointed in your September 20th answer to Dr. Piccone's letter of August 18th. As Chairman of the Mayor's Drug and Alcohol Executive Commission of the City of Philadelphia, I feel it necessary to convey to you the grave concerns that the Commission has in regard to the serious cuts in the Federal block grant treatment dollars. As you know, the most recent 25% cut is yet another reduction added to the cutbacks received in the last two years. Our primary concern is how it is going to be possible to continue to deliver needed services to the citizens of Philadelphia.

Unfortunately, we have a keen sense of how services and clients will be impacted by the reduction. The Fiscal Year 1985 Plan update recently submitted to you by CODAAP bore my signature. The "Plan" reflects those service losses outlined in Dr. Piccone's August 18th correspondence to you. We have a very much overutilized system at the present time. Providers are asking their already overloaded staffs to continue to be responsive to the increased demands on the system. We also are insisting that the quality of care be maintined. However, we are concerned about continued stress on our system over the long term. The cummulative cuts pose a definite threat to our ability to be accessible, responsive, and effective.

We were disappointed that your letter did not respond to the regional or methadone issues we presented. Several contiguous counties to Philadelphia have recently been in touch with CODAAP to explore ways to avoid losing their methadone maintenance capability. This serious dilemma could leave Philadelphia as the only methadone maintenance provider in the southeast region. Because of this ODAP action, client access to services would be severely limited.

We remain concerned about the methodology by which ODAP has implemented funding policies. We feel this has resulted in unfair distribution of State and Federal Funds. Furthermore, if, as you stated, ODAP continues to allocate new funds in the same manner, the City of Philadelphia will suffer. The much more relevant methodology would be to distribute funds on the basis of demonstrated need. We will continue to advocate for a needs-based allocation process. The Mayor's Drug and Alcohol Executive Commission has voiced strong feelings in this regard and we will be working closely with service providers and our legislative delegation toward this more equitable approach.

In summary, it remains our hope to work closely with you toward the common goal of providing needed services to the citizens of Philadelphia. We again would like to reiterate that Philadelphia would like to be included in the major committees which you have formed and which impact on our funding. We would also like to meet with ODAP representatives to pursue alternatives to these funding cutbacks, which for Philadelphia alone will mean the loss of approximately $2,000,000.00. I would like to suggest that we meet as soon as possible to discuss the ramifications of ODAP's most recent policy initiatives and develop cooperative strategies to address this crisis.

I look forward to hearing from you at your earliest convenience.

Very truly yours,

JOSEPH R. GLANCEY
Chairman

TESTIMONY OF ARTHUR JAFFE, PRESIDENT, NEW YORK STATE ASSOCIATION OF SUBSTANCE ABUSE PROGRAMS, SUBMITTED FOR THE RECORD TO THE HOUSE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

On behalf of the New York State Association of Substance Abuse Programs, I would like to thank the Committee for conducting this public hearing.

Our Association is comprised of professionals in the field of drug abuse prevention, intervention and treatment working throughout the State. Members include persons from all eight regions of New York State as identified by the New York State Division of Substance Abuse Services.

As President of the Association, I will attempt to reflect a New York State modality response to the Federal strategy. This will include school based prevention, methadone treatment, and drug free treatment. I will be starting with a prevention overview.

The problems inherent in the process of growing up have never been more complex and yet more common among our youth. Drug and alcohol use is but one example of the kind of self-negating option available to our youth that is so alluring in its release and so destructive to the very process of growth.

To offset the allure of substance use requires more than simply telling children that using substances can hurt you, just as helping children to mature requires more than telling them to grow up. Children need the support of adults who have accurate information, the alternative activities, the counseling skills -

all those things that encourage the mental health of the child even as they discourage the non-solutions of drug use.

As growing up is a complex process, so also is the substance abuse problem. It involves the individual who makes a decision to try drugs, the family, school and community who are affected by the individual's decision, the criminal justice system, medical and legal professions, prevention, intervention and treatment programs who provide help for the individual, governmental agencies and their bureaucracies who have to deal with the problem as a system: locally, nationally and internationally, --in essence, it involves all of us.

New York State was and is a leader in facing up to the drug problem and probably has spent more state dollars providing services to the victims of drug abuse than any other state in the nation. New York probably leads the nation in the number of persons who are drug involved and/or drug dependent. New York also is a living laboratory which has been developing programs to address the drug problem for twenty years. Few programs throughout the nation did not originate in New York or be tested by us in New York, kept or disposed of according to the results. Although we do get recognition for having the most drug abusers, we rarely get recognition for the experience and expertise that we have in this field.

The role of the federal government has been far less responsive and responsible when compared to New York State. The present administration focuses on criminal justice and enforcement areas.

Inspired leadership at the federal level is required to recognize the complexity of the issue of substance abuse and to fashion its response. It is most unfortunate that President Reagan and Mrs. Reagan offer a great deal of lip service regarding their concern for the problem and for its victims, while at the same time the federal government fails to provide adequate resources to prevent, treat, rehabilitate and employ the victims of substance abuse. It is unfortunate that the federal government is more interested in developing comic books as a means of prevention rather than providing services. A policy that overemphasizes education assumes that drugs are being used by kids because they are misinformed. Scare tactics did not work fifteen years ago and will not work today. Reading and hearing about someone else's experience with the drug scene will not keep a young person from trying drugs or using them. The Federal Government telling youngsters not to use drugs because they are bad for you is not much better than a parent telling a misbehaving child to grow up or you're going to get into trouble. For the youth the question remains: how am I to grow up, how do I learn new ways of handling these feelings, these recurring problems -

and who is to help me learn them?

The Federal Government further limits any advantage that might be gained from its emphasis on information dissemination through a regressive formula for funding prevention services. In effect, what the White House has done in its ADM block grant is to reduce the appropriation level for any drug service and then set aside 20% of the lowered appropriation for prevention. Such a policy has led to the long waiting lists in New York State for treatment. The Federal Government fosters the concept of volunteerism in the prevention field with little attention to the role of the professional. We do not have volunteers taking the place of doctors, lawyers, judges, and we should not have volunteers taking the place of providing counseling services to our needy youth. In general, there has been a lack of commitment on the part of the Federal Government with regard to funding the continuum of substance abuse services from prevention through treatment and chemotherapeutic approaches, which represent a cost effective, interdependent network of services that is chronically underfunded and in need of immediate expansion.

I urge you to take up the cause in the Congress and with the White House so that adequate services are available to the victims of substance abuse, throughout the nation, but particularly in New York State where the concentration is so heavy. Services must be available in all parts of New York State, in every school district and community.

PREPARED STATEMENTS

OPENING STATEMENT
BY
CHAIRMAN CHARLES B. RANGEL
SELECT COMMITTEE ON NARCOTICS
ABUSE AND CONTROL
UNITED STATES HOUSE OF REPRESENTATIVES

HEARING ON
FEDERAL DRUG STRATEGY

10:00 A.M., NOVEMBER 1, 1983
2226 RAYBURN BUILDING

Good Morning, ladies and gentlemen. This morning the Select Committee continues its review of the Reagan Administration's drug policies. We are pleased to have as our sole witness today Dr. Carlton Turner, the President's Special Assistant for Drug Abuse Policy, who will outline the Administration's 1982 Federal Strategy for Prevention of Drug Abuse and Drug Trafficking and discuss the role of the White House Drug Abuse Policy Office in developing and implementing this strategy.

For the past several months, the Select Committee has conducted an extensive investigation of the drug abuse problems confronting our nation. Through public hearings, meetings with government and private officials both here and abroad, and on-site inspections of narcotics growing areas, we have attempted to look at all aspects of this problem. What we have seen and heard has been very disturbing.

Heroin continues to flood the northeast region of the country and indicators of heroin abuse have jumped dramatically in New York and other northeast cities. Increased heroin activity is not confined to that area, however, as Los Angeles, Detroit, San Antonio and other cities are now reporting sharp increases in heroin abuse and trafficking activity.

THE AVAILABILITY OF COCAINE IS GREATER THAN EVER BEFORE, AND THE GLUT OF COCAINE ON THE MARKET IS DRIVING PRICES DOWNWARD.

TREATMENT PROGRAMS ARE OPERATING AT OR ABOVE 100 PERCENT CAPACITY, THE DEMAND FOR THEIR SERVICES FUELED BY THE READILY AVAILABLE SUPPLIES OF ILLICIT DRUGS. DESPITE THE INCREASING NEED FOR TREATMENT AND PREVENTION SERVICES, FEDERAL BUDGET CUTS ARE FORCING REDUCTIONS IN THESE VITALLY NEEDED PROGRAMS.

STATE AND LOCAL CRIMINAL JUSTICE SYSTEMS -- POLICE, COURTS AND PRISONS -- ARE STAGGERING UNDER THE BURDEN OF DRUG-RELATED CRIME. DRUG TRAFFICKING IN SOME PARTS OF OUR MAJOR URBAN CENTERS PROCEEDS UNCHECKED.

FEDERAL LAW-ENFORCEMENT OFFICIALS WHO TESTIFIED BEFORE THE COMMITEE IN SOUTH FLORIDA RECENTLY CONCEDED THAT THE SOUTH FLORIDA TASK FORCE ON CRIME IS NOT ACHIEVING AN APPRECIABLE REDUCTION IN THE FLOW OF ILLICIT DRUGS THROUGH THAT REGION OF THE COUNTRY.

ILLICIT DOMESTIC MARIHUANA PRODUCTION IS A MAJOR AND GROWING INDUSTRY. FEDERAL EFFORTS TO CONTROL THIS ACTIVITY ARE INADEQUATE TO THE TASK.

In Colombia, Peru, Bolivia and Jamaica, where the Select Committee visited in August, illicit cultivation of coca and marihuana is out of control. The situation is compounded by our Government's failure to put into place a bold international narcotics control policy.

In short, we appear to be losing the battle against drug abuse on nearly all fronts.

We welcome Dr. Turner here today and look forward to the opportunity to discuss with him how the Federal Government can provide effective leadership in meeting these grave national problems.

STATEMENT

by

WILLIAM POLLIN, M.D.

DIRECTOR

NATIONAL INSTITUTE ON DRUG ABUSE

BEFORE THE

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

U.S. HOUSE OF REPRESENTATIVES

November 2, 1983

Mr. Chairman, I appreciate your invitation to discuss the role of the National Institute on Drug Abuse in reducing drug abuse in America. I would like to summarize the dimensions of the problem, where this Institute fits into the overall Federal Strategy for combating it, and what our specific activities and priorities are at the present time.

Drug abuse is clearly a major public health problem with unique characteristics. First, drug use patterns can change with great rapidity. Over the last two decades, for example, there has been approximately a 30-fold increase in the use of marijuana by American young people. Second, there are illegal and highly profitable activities undertaken worldwide to actively promote drug abuse. Recognizing early on the complex nature of the drug abuse problem, Congress in its passage of the Drug Abuse Office and Treatment Act of 1972 added a vigorous prevention and treatment component to the existing law enforcement efforts. Since that time, Federal policy has consistently encompassed both a demand and a supply reduction effort. The demand reduction program is intended to dissuade the nonuser from experimenting with drugs, to deter the occcasional user from progressing to the abuse of drugs, to make treatment available for abusers of drugs who seek it, and to help the former abuser become a productive member of society. It should be noted that new young users have been found to be the most common vectors-- that is, sources of spread--in patterns of drug abuse. Involving them in treatment thus reduces demand in multiple ways. The supply reduction program is intended to minimize the number of new users, to increase the number of old users who abandon use, and to decrease the consumption of current users by reducing the supply of illicit drugs.

As you are aware, the 1982 Federal Strategy for Prevention of Drug Abuse and Drug Trafficking issued by the White House Drug Abuse Policy Office sets the tone and direction, within a flexible framework, for the Administration's current efforts in both the supply reduction and the demand reduction areas. The Strategy benefits greatly from the President's personal leadership and the involvement of the Cabinet. Two Cabinet Councils--the Cabinet Council on Legal Policy and the Cabinet Council on Human Resources--are directly overseeing the implementation of the Strategy. The Secretary of Health and Human Services has been designated as the Chairman Pro Tempore of the Cabinet Council on Human Resources. The Cabinet Councils have designated beneath them working groups to coordinate activities and to track the progress of the goals set forth in the Strategy. Both the Administrator of the Alcohol, Drug Abuse, and Mental Health Administration and I, as Director of the National Institute on Drug Abuse, actively participate in these mechanisms for oversight and coordination of the Federal effort in the drug area.

NIDA's specific role in carrying out the Federal Strategy lies primarily in the area of demand reduction, though we also play an important role in supply reduction through cooperative efforts with the Drug Enforcement Administration and the State Department. As States took over the responsibility for managing the delivery of drug abuse treatment and prevention services with passage of the Alcohol and Drug Abuse and Mental Health Services (ADMS) Block Grant program, our role became one of national and international leadership in areas that supplemented efforts of the individual States. In carrying out this mission, we are involved in four major areas of activity--research, epidemiology, prevention, and communications.

I would like first to discuss our epidemiology program, for it is our work in this area which allows us to define and substantiate the true dimensions of the drug abuse problem and the progress we are making against it. Data from two major national surveys which we support, the High School Senior Survey and the National Household Survey on Drug Abuse, enable us to estimate the prevalence of drug use in major segments of the American population. The results of these surveys which were reported at the end of Fiscal Year 1982 indicate that our efforts are indeed beginning to bear fruit.

By and large, the 1982 National Household Survey data show some moderation of the upward trends in drug use charted by earlier surveys of the seventies. The 1982 High School Senior Survey also shows that American young people are continuing to moderate their use of illicit drugs. Between 1981 and 1982 nearly all classes of illicit drugs showed declines in current use (i.e., use during the month preceding the survey), with the most appreciable drops occuring this year for marijuana, cocaine, amphetamines, and sedatives. Tranquilizer use and hallucinogen use also showed modest declines. Possible exceptions to this overall picture of declining use occurred for three less frequently used classes of drugs--heroin, opiates other than heroin, and inhalants--none of which showed any overall change in 1982. However, it should be noted that whereas overall national prevalence is level or coming down, subgroups of heavy users can be increasing their consumption and causing increasing medical problems.

As measured by the High School Senior Survey, marijuana use has shown a pattern of consistent decline since 1979. While the proportion of seniors having ever tried the drug has not changed much (60 percent in 1979 versus 59 percent in 1982), the percentage reporting use in the month preceding the study dropped from 37 percent in 1979 to 29 percent in 1982. Of perhaps more significance from a public health perspective, daily use of marijuana has decreased significantly. Between 1975 and 1978, daily use of marijuana among high school seniors increased from 6 to 11 percent. However the decline since 1978 has been almost as dramatic. In 1982, active daily use of marijuana was back down to approximately where it was in 1975, at 6 percent, or about one in every 16 seniors. This decrease is particularly important because of the statistically significant relationship between use of marijuana and use of other drugs. There is consistent evidence from a number of sources about the strength of marijuana use as a predictor of subsequent involvement with other illicit drugs.

The two most commonly used legal drugs, alcohol and tobacco, continue to be used at high levels. Nearly all young people have used alcohol by the end of their senior year and the great majority have used in the prior month. Similarly about 35 percent of high school seniors smoke cigarettes on a regular basis.

In sum, both of these surveys indicate that the use of many illicit drugs has declined, or is declining, significantly from the peak levels attained during the late seventies. These reductions in drug use have resulted from multiple factors. Notable are changes in perceived health risks, levels of peer rejection of drug use, levels of parental intervention, and a reduction in the proportion of youth in our population. Similar changes are also reflected in the more recent findings (August 1983) of the California Opinion Index. The Field Institute, which has been conducting this survey for many years, sampled public opinion in California relative to marijuana. During the 4 years since its last poll on this issue, in 1979, it found that there has been a sharp drop in use and a sharp increase--from 36 percent to 54 percent--of Californians favoring stricter laws, or stricter enforcement of laws, against marijuana. This shift in attitude was due in large part to the reactions and opinions of a growing body of ex-users. The key data from this most recent survey in a state which has usually led the nation in drug attitudes and behavior include the following:

Marijuana use among adults	1983	1979	1976	1975
	%	%	%	%
Have ever tried	43	42	35	28
Current smoker	12	17	13	9
Former smoker	31	25	22	19
Never used	57	58	65	72
(Base)	(763)	(498)	(1008)	(1011)

What should be done about laws pertaining to marijuana?	1983		1979		1969	
	%		%		%	
Pass new and even tougher laws	31	54	20	36	49	75
Strictly enforce present laws and penalties	23		16		26	
Keep present laws but make penalties less severe	11		16		9	
Legalize it with age and other controls	29	32	34	42	10	13
Legalize it for purchase by anyone	3		8		3	
No opinion	3		6		3	
(Base)	(763)		(498)		(1011)	

Still, despite this generally good news about the direction in which things have been moving, the drug abuse problem among Americans, and particularly among American youth, is far from being solved. It is still true that:

•Roughly two-thirds of all American young people (64 percent) try an illicit drug before they finish high school.

•At least one in every sixteen high school seniors is actively smoking marijuana on a daily or near daily basis, and fully 20 percent have done so for at least a month at some time in their lives.

•About one in sixteen seniors is drinking alcohol daily, and 41 percent have had five or more drinks in a row at least once in the past two weeks.

•One-third of the American household population over age 12 have used marijuana, cocaine, heroin, or other psychoactive drugs for nonmedical purposes at some time during their lives. In addition, approximately one in every five Americans in households surveyed have used these drugs during the past year.

Continuing priority attention and concern must be given to the national drug abuse problems we face. Although the overall proportions of new and current drug users are decreasing or level, they probably remain the highest in the Western industrialized world. The adverse cost to society, particularly of drug-related crime and corruption, also remains unacceptably high. By some estimates, the total annual cost of drug abuse to society is close to $100 billion. Of this figure, approximately $15 billion is conservatively attributable to the impact of drug abusers on the health care system, the law enforcement and judicicial system, the employment market, and general welfare and social service systems. Another $70 to $80 billion in annual costs may result from the association between drugs and crime.

The destructive effects of drugs on the health of those who abuse them are a second major concern of ours. We gather information on current, acute negative health consequences of drug use, such as drug overdoses, through the Drug Abuse Warning Network (DAWN). Through the DAWN system, which is comprised of 758 emergency room and medical examiner facilities located primarily in 26 metropolitan areas throughout the U.S., NIDA receives reports on drug-related cases on an ongoing basis. Current information from this source indicates that while the rapidly increasing epidemic of drug use in this country during the 1960s and 1970s has finally begun to recede, the negative health consequences associated with drug use have not abated.

For example, over the past three years--from July, 1980 to June, 1983--emergency room visits related to heroin increased in many cities throughout the country. None of the metropolitan areas sampled showed a decreasing trend during this time. In recent months, the overall trend in heroin mentions has begun to show signs of leveling off in New York, has leveled off in Los Angeles, and shows signs of small decreases in Philadelphia. Only Detroit and Phoenix are still showing a strong increasing trend.

Over the same three year period, there have also been increases in emergency room visits related to cocaine in most cities. In recent months the overall cocaine trend has shown some signs of leveling, as has the trend in New York. However, the emergency room visits related to cocaine are still increasing in Detroit, Los Angeles, New Orleans, Miami, and Philadelphia. Reported cocaine deaths went from 186 in FY 1981 to 204 in FY 1982, and stood at 62 for the first quarter of 1983. These figures do not include cocaine deaths in New York City.

We collect data not only on the incidence and prevalence of drug abuse and its acute health consequences, but also on drug abuse treatment. The National Drug and Alcoholism Treatment Utilization Survey (NDATUS) looks at the scope and use of drug abuse and alcoholism treatment and prevention resources throughout the United States and its territories. NDATUS provides information on a substantial portion of the treatment resources available throughout the United States. Since treatment is a major focus of this hearing, I would like to highlight some of the findings of the 1982 NDATUS.

A total of 3,018 drug abuse treatment units participated in NDATUS last year. About half of these units (1,514) treated only drug clients, while the remainder were part of combined units treating both drug and alcohol clients. The more than 3,000 drug abuse treatment units surveyed reported the capacity to treat almost 200,000 (196,289) clients on a given day. Of these treatment slots, 173,479 or 88 percent were being utilized by clients at the time of the survey. The majority (58 percent) of all clients in treatment were in a drug-free modality, 42 percent were in methadone maintenance, and 82 percent were in an outpatient environment. The treatment units reported in excess of 500 million in financial support, 66 percent of which was provided by Federal, State, and local governments. Private sources, including health insurance, donations, and client fees accounted for another 18 percent, while other public sources, including welfare and health insurance, accounted for the remaining 16 percent.

In Fiscal Year 1984, NDATUS is proposed as a joint effort with the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the States. This biennial voluntary effort will be modified to more closely reflect the capabilities and needs of the States, and will be used by Federal and State agencies to ascertain the kinds of treatment available, numbers and demographics of clients treated, and fluctuations in finding allocations for those services.

The Omnibus Reconciliation Act of 1981 deleted the requirement that States collect and report client-specific data. Most States have maintained some client-based reporting system, in many cases with a reporting format similar to that pereviously used in reporting Client Oriented Data Acquisition Process (CODAP) data to NIDA. There remains, however, considerable variability from State to State in the extent of information gathered and in the way it is analyzed. Because such client information is critical for assessing consumption and use pattern changes in illicit drugs such as heroin and cocaine and is vital to national projections and comparisons between and among States and localities, we are actively working to develop a way of effectively collecting the data we need from the States on a voluntary basis.

In addition to our important activities in the area of epidemiology, NIDA has the primary Federal responsibility for research into the use and abuse of drugs. Prior to passage of the Omnibus Budget Reconciliation Act in 1981, NIDA's major budget commitments were directed toward prevention and treatment programs (66 percent), with a much smaller amount (18 percent) allocated for efforts in basic biomedical, behavioral, treatment, abuse-liability, and drug hazard research, and in epidemiology. With the transfer of drug abuse treatment and prevention services to the States under the Block Grant program, NIDA has reorganized in order to fulfill the Institute's substantially modified role, in which research constitutes 77 percent of our total budget. It should be emphasized that the great bulk (86 percent) of our funds for data collection efforts are derived from our research budget. This is one reason why we are so concerned with the budget levels recommended by the House-Senate Appropriations Conference Committee, which result in an effective 4.6 percent reduction from research funding levels requested in the President's budget for FY 1984. Programmatically, this means a 16 percent reduction in the number of new and competing program grants that can be funded, when compared with the President's budget.

In order to implement these research efforts, NIDA has established a planning process consonant with its long-term goals to gain new knowledge of the basic mechanisms underlying substance abuse and to develop new behavioral and pharmacological methodologies for the prevention, diagnosis, and treatment of drug abuse. In this context, it is becoming increasingly clear that drug abuse is a problem which is not just social in nature. There is an important biological component involved in drug abuse, the exploration of which is a major focus of our research. During the past five years, we have accumulated sufficient new scientific knowledge of the effects of drugs on brain chemistry and behavior to now anticipate, for the first time, the ability to empirically test specific biological hypotheses concerning the etiology of addictive disorders. It is reasonable to believe such studies can produce major advances in the field of substance abuse treatment.

For example, NIDA-sponsored research was responsible for the identification and isolation of opiate receptors within the central nervous system and the subsequent discovery of endogenous opiate-like substances. These findings provide the following testable hypothesis for a biological component of addiction: that addiction may be the result of disorders in the endorphin-enkephalin system which could result in the decreased production of endorphins and enkephalins (as in the diabetes model where the disease results from decreased production of insulin), or reduced responsivity resulting from reduced receptor sensitivity. Tests on these hypotheses are just beginning, and their findings may open new methods for the prevention and treatment of drug abuse and other health problems. Our basic drug research will continue to concentrate on drug action in the brain and central nervous system. Work will proceed on opiate receptors, endorphins, and enkephalins, and on testing the hypothesis that similar mechanisms are involved in the abuse of non-opiate drugs.

Much has also been learned about both the acute and chronic effects of marijuana use. It is now clear, for example, that acute intoxication with marijuana interferes with many aspects of mental health functioning and poses a major impediment to classroom performance. The drug also has serious acute effects on perception and skilled performance, both of which are involved in driving and a number of other tasks. In addition to the acute effects, known effects of chronic marijuana use include impaired lung functioning and decreased sperm counts and sperm motility. Preliminary evidence also suggests that marijuana may interfere with ovulation and prenatal development, may impair the body's immune response, and may have adverse effects on heart function. It has been learned that the by-products of marijuana remain in body fat for many weeks, with consequences whose full significance is still under study. The metabolic release of these stored by-products may produce residual effects on performance after the acute reaction to the drug has worn off.

Of special concern are the long-term developmental effects in children and adolescents who are particularly vulnerable to the drug's behavioral and psychological effects. Chronic use of the drug appears to relate to symptoms characterized by loss of motivation and energy, diminished school performance, harmed parental relationships, and other behavioral disruptions of young persons. Although more research is required, recent national surveys report that 40 percent of heavy users experience some or all of these symptoms.

Future studies of marijuana will focus on determining the long-term, and possibly irreversible, health effects of its use of the physical, psychological, and social development of adolescents and on the offspring of marijuana users. A second focus is on finding more effective ways of providing treatment to chronic marijuana users. Finally, our research will seek basic information about the mechanism of action of marijuana on the brain.

Because of the wide-scale abuse of cocaine, our research program is including an emphasis on this drug. There is special concern about more dangerous modes of administration, such as smoking "freebase." In addition, the effects of cocaine use--psychosis, cardiovascular stress, and even death--appear to be related to dose. In an attempt to identify the underlying mechanisms that lead to "cocaine psychosis," investigators will focus on the parmacokinetics of cocaine and its primary site of action in the nervous system. Researchers will also be trying to define the characteristics of the user prone to develop dependency on the drug.

We have continued to develop new and more effective drug abuse treatment agents. Emphasis has been placed on coordinating efforts to make naltrexone and LAAM (levo-alpha-acetyl-methadol)--two promising new therapeutic drugs for narcotic addict detoxification and treatment--more readily available. Analyses of other therapeutic agents are also being carried out and efforts are being undertaken to evaluate the utility of clonidine and related drugs in drug abuse treatment.

Other research and scientific reviews have helped establish the addictive properties of nicotine. Tobacco smoking has been found to be a prototypic dependence process having both pharmacologic and psychological effects. In particular, the euphoriant effects of nicotine are strikingly similar to those of morphine and cocaine when they are taken intravenously, and nicotine has been found to be a reinforcer for animals. Converging lines of research indicate that cigarette smoking is strongly related to the onset of marijuana smoking, and subsequent use of other drugs. For example, among all teenagers in 1982, current cigarette smokers were 11 times more likely to be current marijuana users and 14 times more likely to be current users of heroin, cocaine, and/or hallucinogens, than non-smokers. This finding indicates that prevention efforts targeted toward reducing young peoples' initiation into cigarettes can have long-term beneficial effects not only in reduction of smoking, but also in the use of all other drugs.

Other NIDA research will focus on predicting the abuse liability of new drugs. There will be studies of the interactions between tranquilizers and other drugs of abuse, particularly alochol, tobacco, marijuana, and PCP. Other studies will look at the possible effects of these widely prescribed drugs on driving performance and other psychomotor skills.

While much of the basic drug abuse research we carry out has implications for treatment, part of our research program is specifically focused on evaluating specific treatment modalities. Last year, for example, preliminary results became available from the Treatment Outcome Prospective Study (TOPS), a longitudinal investigation of 12,000 patients in treatment at more than 50 selected federally funded drug treatment programs during 1979 to 1981. Data from TOPS replicate the findings of earlier studies that individuals show considerable improvement after treatment, measured by the outcome criteria of decreased drug use, decreased criminal activity, and increased productive behaviors, such as employment.

Both large-scale followup studies and smaller program-based evaluation efforts have established that drug abuse treatment does work. In the future, emphasis will be placed on smaller multiple program comparisons designed to answer specific questions, such as which patients benefit most from particular types of treatment, and additional work will be carried out using controlled clinical trials, where feasible, to answer specific questions about the effectiveness of a given intervention.

Efforts will also be made to evaluate the effectiveness of aftercare activities with various subgroups of patients. Among the kinds of activities to be assessed are self-help initiatives for clients leaving treatment, coping strategies developed for drug abuse clients, and the use of staff and community members in innovative programs designed to keep patients drug-free in the community.

In addition, many of our research activities have been and will continue to be targeted to families and youth and the development of drug abuse prevention/intervention models. This prevention research focuses on the influence of family and peers in preventing drug abuse as well as determining the differential effectiveness of particular prevention techniques such as individual and family skills training. We are also supporting research to explore how family functioning, family life events, and changes affect patterns of adolescent substance abuse.

For the past five years, we have placed high priority on the careful evaluation of a number of drug abuse prevention strategies targeted at teenagers. These strategies are all designed to prevent, delay, and reduce the onset of drug abuse and related social problem behaviors. The most promising identified thus far include "social skills training," which focuses on communication skills, and "positive peer pressure techniques," which train youth to resist the subtle pressures from peers or from the media to use cigarettes, alcohol, and marijuana. A 5-year grant has been awarded by NIDA to implement and test a school-based prevention program to offset peer pressure through the use of positive strategies for saying "no" to drugs.

NIDA recently held a technical review on Intervention Strategies in the Prevention of Adolescent Drug Abuse, that included an assessment and evaluation of the state of the art in prevention strategies, as well as proposed goals to be achieved in the area of prevention within the next five years. The results of that review will be disseminated to the field as soon as they are available.

In addition, two new grant announcements have just been issued in the area of prevention research. The first, entitled "Drug Abuse Prevention Research Announcement," included parent/family skills training research, and emphasis on school-based programs to develop skills in resisting peer pressures to use drugs. Although adolescents are a primary focus of NIDA's intervention research, study of other population segments that may be at risk is also encouraged in this research announcement. The second announcement, entitled "Family Therapy and Prevention Research Announcement," focuses specifically on the efficacy of family therapy in the treatment of adolescent drug abusers, and on the prevention of drug abusing behavior in the younger siblings of adolescent drug abusers.

Our long-term policy in both treatment and prevention is to develop knowledge, to provide technical assistance and information, and to rely upon the States, local communities, and voluntary organizations for provision of direct services and the majority of funding for those services. For the past 6 years, our primary mechanism for technical assistance in the prevention area has been Pyramid, a nationwide resource sharing network that puts State and local community groups in touch with the resources they may need to mount effective prevention programs. Pyramid has assisted State governments in planning, implementing, monitoring, and evaluating prevention programs. It has also been responsive to parents groups, schools, businesses, and industry in their efforts to carry out prevention activities.

We have also supported community resource mobilization through replication of Channel One, in which the public and private sectors work together to initiate alternative prevention programs for youth, through their participation in projects to benefit their local communities. Over 165 projects involving more than 80 private sector business entities are in operation in 46 States and Territories. Of these, 102 were developed in just the last 2 years.

Pending demographic changes in the makeup of our national population indicate the need to place greater emphasis on public education/prevention programs directed towards minority communities. Specifically, while teenagers as a percentage of the total population are expected to decrease, their numbers are expected to increase dramatically among Blacks and Hispanics, thus substantially raising the risks of drug abuse among these population groups. Therefore, the Institute is developing a long-range strategy in prevention, communications, treatment, and research to reach these audiences. We are planning to develop cultural translations of relevant prevention materials and will be developing media communications approaches to reach minority young people. Under the present Pyramid contract, which began May 1, 1983, NIDA has expended $11,868 or 40 percent of the funds for on-site technical assistance ($29,848) for ethnic minority prevention initiatives. These funds will be used for imaginative networking and consultant services.

One of the ways in which we provide technical assistance to the public in the area of prevention is through a toll free telephone service (800-638-2045), initiated just six months ago. Approximately ten percent of those using this service have specifically identified themselves as minority-focused programs, and we have provided them with assistance in identifying materials targeted for Black, Hispanic, or American Indian populations. Many of these materials have been developed by NIDA, while others come from both the Center for Multicultural Awareness and the Pyramid Project. 1,200 of the data items in our computer based reference system and repository were transferred from the Center for Multicultural Awareness. New ethnic minority focused materials will be added to the repository to ensure staff access to curent information relevant to prevention issues among ethnic minority populations. We plan, for instance, to dedicate one issue of our "Prevention Networks" publication to a discussion of prevention strategies for minority communities. This publication will be available for public distribution in early 1984.

Since its inception we have supported the parents movement by lending technical assistance, convening workshops and conferences, and publishing a variety of materials. Parents, Peers and Pot was developed for parents groups and has been the most widely requested NIDA publication. Recently we developed Parents, Peers and Pot II: Parents in Action, a book describing the formation and experiences of selected parent groups in urban, suburban, and rural communities. In 1981, NIDA sponsored a national conference dealing with parents and drug abuse prevention. Discussion focused on community mobilization and networking, parenting skills, and other family-centered approaches to drug abuse prevention. During 1981 and 1982, NIDA also convened four regional workshops to promote collaboration between parent groups, State agencies, and prevention and treatment programs. There are now well over 3,000 organized parent groups working to promote an environment in which children are getting "don't do drugs" messages from parents, schools, the media, and the community at large. Currently, NIDA is collaborating with ACTION and the National Federation of Parents to expand and enhance involvement of ethnic minority families in the parent movement for drug free youth. The Institute has recently committed $25,000 for its Multicultural Family Initiative, which is working toward the development of an ethnic minority family network.

In an effort to continue to keep the public, and youth in particular, aware of the health and psychological effects of marijuana, NIDA in FY 1982 awarded a contract for the production of six marijuana public service announcements. These radio and television spots will deal with the effects of marijuana on driving, learning, and family relationships. NIDA has awarded another contract, to the Advertising Council, Inc., to develop a national drug abuse prevention campaign which will be launched this month. The basic thrust of this two-pronged campaign--aimed at teenagers 12 to 14 years old and at parents--is to accelerate the downturn in the use of marijuana and extend this downturn to other drugs.

NIDA's National Clearinghouse for Drug Abuse Information serves as the Federal center for collection and dissemination of drug abuse information, providing services to both lay and professional audiences. During the past two years, over 7.5 million publications were distributed in response to requests from parents, young people, community groups, treatment staff, researchers, and State officials. An additional one million publications have been distributed through a national supermarket dissemination program.

In addition, NIDA has substantially increased our efforts with the private sector. One such effort is a major public service program which Peoples Drug Store launched in early October. The program, entitled "Your Kids and Drugs--Spot It, Stop It," makes available at more than 500 Peoples Drug Stores a series of pamphlets on drug abuse and how to stop it. Our experience demonstrates that multiple private sector initiatives like this one can be more effective than a single governmental effort.

Along with the production and dissemination of drug abuse information, we are endeavoring to stimulate the media to communicate how the problem of drug abuse negatively affects entire communities and how it can be prevented. Media messages about drug abuse are beginning to change for the better. To encourage this, NIDA is collaborating with the Scott Newman Foundation on the annual Scott Newman Award. This award, first given in 1981, is presented to television programmers who broadcast TV shows that convey a strong drug prevention theme.

Drug abuse is a problem that cuts across all social, economic, and age groups, and all of these deserve our attention, but in a time when it is necessary to extract maximum benefit from the Federal investment, it is extremely important that we set clear priorities. During the next fiscal year (FY 1984), our efforts will focus on continuing to support a comprehensive and well-balanced basic research program in drug abuse, to define and implement successful model prevention and treatment strategies, and to move toward a position where the results of this research and the application of these methods can be confidently disseminated to the community level. Developing new data systems to accurately and comprehensively track the utilization of drug abuse treatment programs and to describe patient-addicts in treatment is another priority area. In our efforts to combat youthful drug abuse, we will also continue our technical assistance to private sector and family based prevention activities, such as those of local parents groups. Efforts in all of these areas are already paying dividends, as reflected, for example, in the most recent drug use trends I cited at the beginning of this testimony. However, drug abuse remains one of our most serious public health problems, and our response to it must be flexible and multi-faceted.

Thank you for the opportunity to talk about these important issues. I would be glad to answer any questions you might have.

Testimony of Thomas W. Pauken

Director of ACTION

Mr. Chairman, Members of the Committee - Thank you for the opportunity to appear before you today.

As you know, the widespread use of drugs among American children poses a grave threat to them and to our nation's future. The $90 billion illegal drug industry sees young people as its principal market. Marijuana has become one of this country's foremost cash crops and, despite the best efforts of drug enforcement officials, illegal substances continue to pour in across our borders. At the same time, popular media too often portrays drugs as harmless and and even fashionable, so that kids see movies, watch television or read advertisements and come away with a do-drugs message. There has been gradual improvement in the past several years--I'll speak of that a bit later--but the situation we are left with remains appalling. The fact is that marijuana and alcohol, not to mention cocaine, PCP and LSD, and in some cases heroin have become as normal a part of school life as sports and studies.

A survey made for the Congress several years ago reported that 90 percent of America's high school seniors considered marijuana "fairly easy to obtain." In 1976, the National Institute for Drug Abuse reported that one in nine high school seniors smoked marijuana every day. That number has been cut nearly in half, but pot-smoking is still dangerously commonplace, even among junior high school students. A whole range of very deadly drugs continues to invade our schools. Take PCP, for instance. The kids call it "angel dust." PCP users risk speech difficulties, memory loss, personality change, violence and suicide. Yet a NIDA study of PCP abuse in Philadelphia found that 92 percent of the PCP users were between 14 and 19 years old. These are the kinds of problems our nation is up against. We're not just talking statistics. We're talking about young lives and lost dreams.

To underline this, let me read a few lines written by a young woman from nearby Fairfax County, Virginia. Her story is one of dozens gathered by a local parents' group called PANDA--the Parents' Association to Neutralize Drug and Alcohol Abuse. They collected essays like this to show school authorities what was going on. Her story begins: "My name is Lora. I'm seventeen years old. The drugs I've done are pot, alcohol, hash, hash oil, ups, prescriptions and cocaine. I started drugs when I was thirteen. At school is where I did a lot of my drugs. Usually it was once or sometimes twice during the day. The teachers considered me a good kid. I'd estimate that 75% of the kids in the high school do drugs of some kind during the school week."

I suppose we all get the picture. But even in this room there may be people thinking how terrible that sounds, and how lucky I am that my children aren't part of this. Well it is sad to say, but if your children are not living surrounded by drugs, they are very lucky and very rare indeed. The truth is that drug abuse is common in every community, in every ethnic and economic group, in nearly every high school and junior high, public or private. And, of course, in areas of economic deprivation. All that is the bad news.

The good news is that Americans have had enough of domination by the so-called drug culture, enough of watching their children's right to happiness and freedom from drugs threatened. Citizens, especially parents, are fighting back and drugs are beginning to lose their grip on young people. I am happy to say that since 1981 ACTION has finally taken a stand in the battle against drugs. We have a formidable enemy but we are finding ways to conquer drugs.

When I came to ACTION nearly three years ago, I was disappointed to find very little being done to stop drug abuse. The most potent force we have to combat drugs--the parents' movement--hadn't even been recognized. To develop ACTION's Drug Prevention Program, we worked with the the President's Office of Drug Abuse Policy and with the First Lady of the United States, Mrs. Nancy Reagan, who has done so much to bring public attention to this serious national problem. In order to shape effective programs, we consulted with the parents' movement and worked with other federal agencies, such as NIDA and the Drug Enforcement Administration (DEA), building a solid information-base and establishing guidelines for our drug prevention drive. Fundamental to our activities are the following tenets: that the absolute best way to fight drugs is with accurate, up-to-date information; that drug prevention begins at home and parents must be educated about drug abuse and organized to fight it; that the notion that marijuana or any other drug is "soft," is a lie, for there is no such thing as responsible drug use among children; and that an effective fight against drugs must involve all sectors of the community--individuals, businesses, schools, church and civic organizations, and the kids themselves.

Guided by these principles, our Drug Prevention Program set out with the following initiatives and goals: to assist the nationwide mobilization of local-level groups of parents and concerned citizens; to support the creation of public forums--national, regional and local--to let people know they need no longer feel held hostage by drugs; to develop and distribute accurate, timely information and media materials; to find new ways to involve young people in activities that promote freedom from drugs; to serve as a resource to and partner of organizations and individuals battling drugs and to help build coalitions, seeking allies everywhere they can be found--in private business, from corporations to corner drug stores, in civic organizations, from national entities like the Benevolent and Protective Order of Elks to PTAs and scouting troops in the farthest reaches of rural America, among professional people, from nationally known celebrities to local police chiefs and clergy; to reverse the promotion of drugs by the media; to support the efforts of volunteers who fight drugs, both in ACTION programs and private voluntary organizations; and to promote effective resources available to the public from other government agencies, federal, state and local.

I would like to outline a number of our major undertakings. In March, 1982, ACTION sponsored the First White House Briefing on Drug Use and the Family, which was hosted by Mrs. Reagan. The Briefing put the issue of drugs and kids on page one, opening a host of efforts across the country. It was attended by corporate and church leaders, government officials, representatives of civic and volunteer organizations, parents and parent group leaders, media and leading entertainment figures.

People like Jack O'Brien, president of McNeil Pharmaceutical, were there to hear the leader of the then-fledgling National Federation of Parents for Drug-Free Youth declare that nearly half the nation's youth considered marijuana harmless to their health.

We at ACTION had believed that pharmacists represented a great potential information resource, and after the White House Briefing, in conjunction with McNeil, designed and implemented the Pharmacists Against Drug Abuse Program (P.A.D.A.), in which 65,000 local pharmacists will be serving as libraries on drug information, distributing hard-hitting, easy-to-understand literature about the kinds of drugs kids use. Our Drug Program was also able to recruit Mr. Michael Landon to serve as spokesman for P.A.D.A. At the outset of the P.A.D.A. program, ACTION conducted an extensive evaluation of the effectiveness of the materials P.A.D.A. uses, and since that time McNeil has conducted five surveys evaluating the program. I should mention that the DEA played a key role in promoting P.A.D.A., and the Defense Department provided studio space to tape a public service announcement made by Mr. Landon. NIDA's publications and research findings were used as resources for the materials.

We have also recruited other public figures to travel the country and speak on behalf of our Drug Prevention Program. For the past two years, actress Melissa Gilbert has addressed young people, met with kids at drug treatment centers, and carried the message about drug abuse to groups like the General Federation of Women's Clubs (GFWC).

Miss Gilbert's very moving presentation to the GFWC convention this year kicked off ACTION's joint project with NIDA to enlist GFWC members--more than a half-million women community leaders--to help local parents' groups and others fighting drugs in the community. ACTION teamed with NIDA to provide materials for this effort. As of last month, Melissa Gilbert was joined by two other well-known performers who want to help kids stay off drugs--Miss Jill Whelan and Mr. Gavin MacLeod of the "Love Boat."

This past summer, the Benevolent and Protective Order of Elks--the country's largest fraternal organization with 1.6 million members--launched, in conjunction with ACTION, a national drug abuse campaign. ACTION designed the Elks' program and I was able to kick it off by addressing their national convention and making the leaders of 2,000 local Elks lodges aware of the great range of resources available to them through ACTION and numerous other public and private sources. As always, we are urging the Elks to contact state and local drug programs before proceeding with their efforts, and to work closely to build an alliance of concerned, informed parents whenever they initiate local projects.

Over the past two years, ACTION has awarded a host of drug prevention grants aimed at mobilizing parents and supporting the work of non-profit organizations active locally in the war against drugs. We provided funds totaling $235,462 to PRIDE--The Parents' Resource Institute for Drug Education in Atlanta. PRIDE grew out of one of the first, highly successful, local drug prevention efforts made by a group of parents, and we believe it very important that the rest of the nation know what worked for them. So we join PRIDE in supporting their toll-free, drug information number and their efforts to help parents around the U.S. set up local groups. PRIDE provides all kinds of educational tools and counsels people with special problems. They offer books, brochures and film rentals that carry the message to schoolboard and PTA meetings. For your information, the free, ACTION/ PRIDE national drug information clearinghouse number is: 800-241-9746.

ACTION provided a demonstration grant in the amount of $124,443 to Convenant House in New York City. Founded by Rev. Bruce Ritter and located in Times Square, Covenant House is a refuge for runaway youth who would otherwise live in the streets, subjected in most cases to drug addiction and exploitation of the most grotesque nature. [Last year ACTION provided the National Federation of Parents (NFP) with a grant of $20,015 to host their first national conference of parents here in Washington.]

The American Council on Marijuana received grants totaling $51,463 to produce and distribute ten informational pamphlets on the health consequences of drugs and to produce, in conjunction with the girl scouts, a youth leader's guide, soon to be available.

Our ACTION regional director in Denver, Naomi Bradford, is chairing the Colorado State Planning Committee for the Chemical People, a powerful program about drugs and youth that will air nationally on public television next month. The State Committee is coordinating efforts with parents' organizations to respond to the massive interest the show will arouse, and convert it to broad-based public involvement in the anti-drug movement. Colorado was also the site of an ACTION sponsored conference - the Colorado Conference for Drug-Free Youth, a meeting ACTION helped plan and hold which laid the groundwork for what is becoming a strong, statewide parents' movement.

Instances of ACTION support of parents' group networking are numerous. In Sacramento, a group called Californian's for Drug Free Youth was provided $40,445 by ACTION that will help them hold two statewide conferences; they aim to network the whole state. Florida Informed Parents, Inc. of Tallahassee, was awarded $18,940 to assist them in broadening efforts to form parents' groups. In Pinellas Park, FL, Operation PAR, Inc. received $10,000; PAR will hold a conference this month called "Prevention Strategies for the Eighties." Another grantee in Louisville--Kentucky Parents for Youth--used $19,094 in ACTION funds to set up education projects that are so good they have won continued funding from the Governor's War on Drugs Program. The Community Council in Action of Jefferson, MO, received $29,700 to fund a conference sponsored by the Missouri Federation of Parents, and North Carolinians Against Drug and Alcohol Abuse in Raleigh used $30,000 in grant funds to hold a drug awareness conference that has gotten movements underway across the state.

In the Bronx, N.Y., we provide a grant of $51,700 to a wonderful program called DARE, the Drug Abuse Rehabilitation and Education program of the Catholic Archdiocese in New York. For the second year, we helped DARE sponsor its annual mini-marathon, in which runners, most of them young people, run through the streets of the Bronx bearing the message that drugs defeat people and help grind them under the heel of poverty--that drugs are the enemy of their future. Last year, 1,000 young runners participated in the marathon, bringing the message to thousands of other kids. The project is training 1000 community leaders in a ten county area and approximately 6000 others.

I am not going to detail the activities here of all of our other grantees, whose education, awareness and parent-networking have helped transform the movement for drug-free youth from a handful of parents' groups several years ago to a full-blown, national drive today. I do want, however, to name our other grant recipients. They are: Big Brothers/Sisters of Nassau County, Hempstead, N.Y.--$19,933; National Youth Work Alliance, Washington, D.C.--$68,122; Dekalb Families in Action, Decatur, Ga.--$43,920; Ohio Federation of Families for Drug-Free Youth, Bexley, Ohio--$19,500; House of Umoja, Philadelphia, PA--$11,525.

In addition to providing grants, we've helped a whole range of non-profit groups with neighborhood, anti-drug projects, providing volunteers, technical assistance, information and education materials, as well as helping create hook-ups among local organizations and appropriate state and federal offices that can help them. In Alabama for instance we supported the first annual Youth Rally in Birmingham, where more than 1,000 kids got together and learned about the effects of drugs on their health. The Rally was put together by the Telephone Pioneers, an organization of Alabama's Bell Telephone employees with our assistance as well as the state Mental Health Department.

On another front, we are working with the leadership of the American Medical Association Auxilliary, offering technical assistance to their state members.

We have also helped local and national organizations print and distribute good information, and we have produced valuable materials as well. One example is the newsletter called Drug Abuse Update, which is regularly produced by Atlanta's Families in Action. Our Drug Program provides resource material to schools, PTA groups, civic organizations and others-material that suggests some of the things communities can do to get kids involved in drug awareness and to get the peril of drugs in the public eye. We suggest working with kids and coming up with interesting formats for local radio and television talk shows. There are countless techniques available--holding essay contests is effective, or having kids plan drug-free dances and celebrations. We have urged local groups to have their mayors proclaim the week of prom or graduation as "Drug Free Week," so that we can raise consciousness of the danger of drug or alcohol intoxication. We lose too many young people at those festive times and we should strive to prevent this.

Mr. Chairman, you and the members of this committee might wish to join those who have taken advantage of ACTION's award-winning videotape about drug abuse by kids and how to stop it. It is a very good basic educational tool, and a good motivator as well.

Finally, ACTION's initiatives in drug prevention are carried out by volunteers in our other programs. Drug awareness is a programming priority for us and will continue as such. Some wonderful things have happened in our Retired Senior Volunteer programs, where we have older volunteers helping rehabilitate youthful offenders who are suffering from drug addiction. In general, the experience and dedication of senior volunteers represents a tremendous resource to communities who need all the hands they can get for awareness and education projects.

Drug prevention is served around the nation by both VISTA volunteers and Young Volunteers in Action, especially in low income areas. For example, in a project jointly run by ACTION and the Alabama Department of Mental Health thirty VISTA volunteers are organizing low-income parents groups. In Los Angeles, on San Pedro Street in Watts, the Young Volunteers in Action (YVA) project recruits low-income kids and teaches them the perils of drugs, providing alternatives to idle days in the street. That San Pedro YVA group created its own recycling center; kids are gathering refuse throughout the community to recycle and sell, and it is going so well they are about to buy themselves a computer. Other volunteers in that YVA project serve as paramedics with the local emergency squad, which is an education in health care and drug addiction that one can't get very easily. The other thing YVA does for low-income families is give the kids who volunteer a boost up the career ladder by teaching them skills and providing experience. We think that is the way to lick drug addiction in poverty areas, by providing opportunities and alternatives to the snare of drugs. So many are longing for the chance to turn it around, to become somebody, for there is no more powerful opponent of drug abuse than a young man or woman who has beaten drugs and is determined to help others. That is the kind of initiative that our Drug Prevention Office seeks to support.

Mr. Chairman, the members of Congress are in a position to be of great help in the battle against drugs. This committee has provided strong leadership in bringing attention to the health consequences of drugs and the effectiveness of the parent movement. You can use your good offices to make drug awareness and the parents' movement more widely known. At home in your districts, you can make the war against drugs an issue. You can see if local government officials are doing anything to help kids stay drug-free. Often it is only a matter of knowing there are things they can do. ACTION stands ready to assist you in this endeavor. This war against drugs--and make no mistake, it is a war--has to originate back home in the community.

I mentioned in starting that daily drug use among high school students had declined over the past five or six years. I do not think it is a coincidence that the decline in the popularity of drugs is apparently in rough proportion to the growth and prevalence of the parent's movement. But despite good progress, we have a very long road ahead. I began this testimony by reading part of a letter by young Lora. She wrote a few more lines that I'd like to read before I close. To sum up the story of her fight with drugs Lora wrote: "Since I am straight, I have returned to school, and I'm going to the school I did drugs at. I now go to class, am involved with what is going on in class, and I don't have to cheat to pass. Kids are doing drugs around me every day, but it takes being strong and looking at the hole I came from thirteen months ago."

As public servants, I don't think there is a greater challenge for us than to help Lora stay strong. The fate of this great land depends on the millions like her who deserve nothing less than the chance to live and study and grow up without seeing drugs everywhere they look. Let us then resolve that we will not surrender the liberty and happiness of our children without a fight, and let us work together to wipe out drugs once and for all.

Thank you very much.

JOINT STATEMENT OF

THOMAS B. KIRKPATRICK, JR.
PRESIDENT

AND

KENNETH EATON
CHAIRMAN

LEGISLATIVE COMMITTEE

NATIONAL ASSOCIATION OF STATE ALCOHOL
AND DRUG ABUSE DIRECTORS
BEFORE THE

SELECT COMMITTEE ON NARCOTICS
ABUSE AND CONTROL

ON

THE FEDERAL STRATEGY FOR REDUCING ALCOHOL AND DRUG ABUSE

NOVEMBER 2, 1983

Dear Chairman Rangel and Members of the Subcommittee:

The National Association of State Alcohol and Drug Abuse Directors (NASADAD) is pleased to have this opportunity to present a statement for the Subcommittee hearing record on the Federal strategy for reducing alcohol and drug abuse. As representatives for the National Association of State Alcohol and Drug Abuse Directors (NASADAD), we will direct our comments to the impact of the Federal strategy on the State alcohol and drug abuse prevention and treatment systems and offer recommendations for strengthing the Federal role in preventing and treating alcohol and drug abuse problems.

State Alcohol and Drug Agencies

The State Alcoholism Agencies and the Single State Agencies for Drug Abuse Prevention were created by the States in response to Congresssional action in the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 and the Drug Abuse Office and Treatment Act of 1972, respectively, to have sole responsibility in the States to plan and administer a Statewide alcoholism and/or drug abuse prevention and treatment network.

Under the Omnibus Reconciliation Act of 1981, which created the Alcohol, Drug Abuse and Mental Health Services (ADMS) Block Grant, the Federal mandate for Single State Agencies was repealed. However, we are pleased to inform you that each State and U.S. Territory has chosen to retain this governmental structure in order to assure effective coordination of alcohol and drug treatment and prevention services at the State and local level and efficient administration of the relevant portion of the Federal ADMS Block Grant.

EXTENT OF THE PROBLEM

THE CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE ARE ALREADY FAMILIAR WITH THE RANGE AND COMPLEXITY OF PROBLEMS WHICH RESULT FROM ALCOHOL ABUSE AND ALCOHOLISM, LICIT AND ILLICIT DRUG ABUSE AND DRUG ADDICTION; THESE ARE PROBLEMS WHICH IMPACT ON EVERY SECTOR OF OUR SOCIETY, WHETHER IT BE LOST PRODUCTIVITY AT THE WORKPLACE, ACCIDENTS ON OUR HIGHWAYS, OR DISRUPTION OF THE FAMILY UNIT. OUR CHILDREN ARE NOT IMMUNE FROM THESE PROBLEMS NOR ARE THE ELDERLY. A 1982 STUDY SPONSORED BY THE ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION (ADAMHA) ESTIMATED THE ECONOMIC COST OF ALCOHOL AND DRUG ABUSE TO HAVE BEEN $65.8 BILLION IN 1977. RECENT ESTIMATES PROJECT THE COSTS OF ALCOHOLISM AND ALCOHOL ABUSE IN 1982 WILL APPROACH $120 BILLION AND THE TOTAL ANNUAL COST OF DRUG ABUSE WILL RISE TO $100 BILLION.

THE PROJECTED ECONOMIC LOSSES DUE TO ALCOHOL AND DRUG ABUSE DO NOT SEEM EXCESSIVE WHEN YOU CONSIDER THE FOLLOWING:

* AMERICAN YOUTH STILL HAVE THE HIGHEST LEVEL OF DRUG ABUSE IN ANY INDUSTRIALIZED NATION;
* 66% OF AMERICAN YOUTH USED AN ILLICIT SUBSTANCE OR A PRESCRIPTION DRUG FOR NON-MEDICAL PURPOSES BEFORE THEY FINISHED HIGH SCHOOL;
* HEROIN ADDICTS, WHEN ACTIVELY ADDICTED, COMMIT AN ESTIMATED 350 CRIMES PER YEAR;
* ALMOST ONE THIRD OF ALL STATE PRISONERS IN 1979 WERE UNDER THE INFLUENCE OF AN ILLICIT DRUG WHEN THEY COMMITTED CRIMES FOR WHICH THEY WERE INCARCERATED;
* AN ESTIMATED 10-15 MILLION AMERICAN ADULTS ARE PROBLEM DRINKERS OR ALCOHOLICS - MORE THAN 3 MILLION AMERICAN TEENAGERS ABUSE ALCOHOL;

- 10,000 YOUNG PEOPLE ARE KILLED EVERY YEAR IN HIGHWAY ACCIDENTS INVOLVING ALCOHOL; AND
- ALCOHOL ABUSE MAY BE RESPONSIBLE FOR 15 PERCENT OF THE NATION'S HEALTH CARE COSTS.

IN LIGHT OF THIS EVIDENCE IT MAKES SENSE IN BOTH FISCAL AND HUMAN TERMS, FOR BOTH FEDERAL AND STATE GOVERNMENTS TO INVEST IN AN APPROPRIATE LEVEL OF FUNDING FOR THE PREVENTION AND TREATMENT OF ALCOHOL AND DRUG ABUSE.

HISTORICALLY, THE FEDERAL GOVERNMENT'S STRATEGY FOR REDUCING ONE OF THESE PROBLEMS, DRUG ABUSE, HAS REPRESENTED A BALANCED APPROACH BETWEEN DEMAND AND SUPPLY SIDE REDUCTION POLICIES. DEMAND REDUCTION STRATEGIES, SPECIFICALLY FUNDING FOR DRUG PREVENTION AND TREATMENT SERVICES, WERE CARRIED OUT JOINTLY WITH STATE GOVERNMENTS. SUPPLY REDUCTION STRATEGIES INCLUDED REDUCING THE AVAILABILITY OF ILLICIT DRUGS IN THE UNITED STATES BY ERADICTING SUCH DRUGS AT THE SOURCE OF PRODUCTION, INTERDICTING INTERNATIONAL DRUG TRANSPORTATION, AND IMPROVING DOMESTIC LAW ENFORCEMENT EFFORTS.

THE FEDERAL STRATEGY DOCUMENT RELEASED IN 1982, HOWEVER, HAS SIGNALED A MAJOR SHIFT IN EMPHASIS TO INTERNATIONAL AND DOMESTIC INTERDICTION OF ILLEGAL DRUG PRODUCTION AND DISTRIBUTION, AND AWAY FROM DEMAND REDUCTION THROUGH PREVENTION AND TREATMENT. THIS MAJOR POLICY CHANGE IS EVIDENT WHEN TOTAL FEDERAL BUDGET OUTLAYS FOR DRUG LAW ENFORCEMENT AND TREATMENT AND PREVENTION SERVICES ARE EXAMINED. FROM FISCAL YEAR (FY) 1980 TO 1983 FEDERAL BUDGET OUTLAYS FOR DRUG LAW ENFORCEMENT INCREASED 30% FROM $537 MILLION TO $695 MILLION WHILE APPROPRIATIONS FOR DRUG ABUSE PREVENTION AND TREATMENT HAVE BEEN REDUCED BY 42%. IN LIGHT OF THIS MAJOR POLICY SHIFT AND THE NEGATIVE IMPACT WHICH IT IS HAVING ON THE SERVICES SYSTEMS, NASADAD ENCOURAGES THE SELECT COMMITTEE TO ASSESS THE IMPACT OF THIS SHIFT AND TO CAREFULLY EXAMINE THE EFFECTIVENESS OF SUPPLY REDUCTION STRATEGIES.

ADMS Block Grant

For the past two years, the Federal government has relied on a significant portion of its support for demand reduction strategies to be channeled through the ADMS Block Grant Program. Overall, the State alcohol and drug abuse agencies have made a smooth transition from the previous Federal categorical alcohol and drug project and formula grant programs to the ADMS Block Grant Program. The smooth transition is in part due to the fact that the State drug agencies had been receiving their project grant dollars through a mechanism similar to the Block Grant for several years — the Statewide services grant — and were already responsible for allocating and monitoring the Federal drug abuse project grants. Also, at the time of the ADMS Block Grant authorization, Federal officials were considering switching to a Statewide services funding mechanism for the Federal alcoholism grants, which at that time were being administered by NIAAA. In fact, five States were participating in a demonstration project testing the feasibility of the Statewide services grant mechanism for the alcoholism project grants. Both the alcohol and drug abuse formula grants were awarded directly to the State alcohol and drug agency, which in turn allocated the dollars where they were needed most.

Since the State alcoholism and drug abuse agencies were already administering three-fourths of the programs eventually folded into the alcohol and drug portion of the ADMS Block Grant Program, the basis for the supposed administrative cost savings associated with the ADMS Block Grant — streamlined and efficient management — was not applicable. The funding reductions accompanying the Block Grant were supposed to be balanced by the increased costs savings realized from the new funding and administrative mechanisms. Unfortunately, for the alcohol and drug

SERVICES PROGRAMS THE SUPPOSITION WAS NOT RELEVANT. RATHER THEY WERE PENALIZED FOR HAVING BEEN ONE STEP AHEAD.

IN FY 1980 (THE BASE YEAR FOR THE ALCOHOL AND DRUG PORTION OF THE ADMS BLOCK GRANT), FEDERAL APPROPRIATIONS FOR THE ALCOHOL AND DRUG ABUSE PROJECT AND FORMULA GRANT PROGRAMS TOTALLED $332 MILLION. IN FY 1983 THE ALCOHOL AND DRUG PORTION OF THE BLOCK GRANT EQUALLED ONLY $222.8 MILLION - A 33 PERCENT REDUCTION FROM FY 1980 LEVELS WITHOUT ADJUSTING FOR INFLATION. IF THE INFLATION RATE OF 10.4 PERCENT IN 1981 AND 6.1 PERCENT IN 1982 IS TAKEN INTO ACCOUNT, THE FY 1983 FUNDING LEVEL FOR ALCOHOL AND DRUG TREATMENT AND PREVENTION SERVICES REPRESENTED A 42% REDUCTION IN REAL DOLLARS.

RECOGNIZING THE INCREASED DEMAND FOR ALCOHOL AND DRUG TREATMENT SERVICES BY THE UNEMPLOYED, MEMBERS OF CONGRESS ADDED $30 MILLION TO THE ADMS BLOCK GRANT FY 1983 APPROPRIATION IN THE PACKAGE OF JOBS AND HUMANITARIAN AID FOR THE UNEMPLOYED. EVEN WITH THIS INCREASE OF $15.2 MILLION (THE ALCOHOL AND DRUG PORTION OF THE ADMS BLOCK GRANT EQUALS 50.76% OF THE TOTAL), FEDERAL FUNDING FOR ALCOHOL AND DRUG SERVICES, WHEN ADJUSTED FOR INFLATION, DECREASED 33% FROM THE FY 1980 LEVEL.

THE FY 1984 APPROPRIATION FOR THE ADMS BLOCK GRANT — $462 MILLION — AS INCLUDED IN H.R. 3913, THE LABOR, HHS, EDUCATION AND RELATED AGENCIES APPROPRIATIONS ACT, CONTINUES THE FEDERAL GOVERNMENT'S REDUCED LEVEL OF SUPPORT FOR ALCOHOL AND DRUG SERVICES. OF THE TOTAL APPROPRIATION, A LITTLE MORE THAN ONE-HALF OR $234.5 MILLION WILL BE MADE AVAILABLE AT THE NATIONAL LEVEL FOR ALCOHOL AND DRUG SERVICES, $4 MILLION LESS THAN THESE PROGRAMS RECEIVED IN THE FINAL FY 1983 APPROPRIATION. A 40% REDUCTION FROM FY 1980 LEVELS, WHEN ADJUSTED FOR INFLATION.

In the Chairman's home State of New York, the funding reduction accompanying the ADMS Block Grant Program has had a devastating impact on the drug treatment system. In FY 1982 when the ADMS Block Grant Program was initiated, Federal support for drug treatment services was reduced 32 percent from the previous year. Unfortunately, the demand for treatment services in New York has not declined by a comparable amount and continues to exceed New York's capacity to respond.

Because of the Federal budget cuts many of the important ancillary services previously made available to clients have been eliminated and treatment capacities reduced. Treatment programs are operating at or above 100 percent capacity and have extensive waiting lists. In addition, in the past five years there has been a 300% increase in the number of persons entering or seeking treatment for cocaine abuse. Heroin-related emergency room episodes in New York have also increased by 107% since 1979.

Many States, with careful budget planning combined with a temporary overlap of Federal funding have been able to maintain a minimum level of services even with the significant reduction in Federal support. In FY 1982, many States received their FY 1982 Block Grant award prior to the expiration of the previous Fiscal Year's project and formula grants. This phenomenon was due to the unforseen delay of previous Federal grant awards in many States where the Fiscal Year award was not made until six months after the beginning of the Fiscal Year. For example, State X applied for and received its FY 1982 Block Grant quarterly allocation on October 1, 1982. However, State X's FY 1981 Statewide services annual grant award had not been awarded until March 1982 (six months after the beginning of FY 1981). As a result, there existed an overlap of Federal funds and the State was able to postpone the negative impact of the

DECREASE IN FEDERAL FUNDING FOR ALCOHOLISM AND DRUG ABUSE SERVICES WHICH ACCOMPANIED THE ADMS BLOCK GRANT. WITH CREATIVE PLANNING, MANY STATES WERE ABLE TO STRETCH THIS CUSHION INTO THE 1983 FISCAL YEAR, BUT IT WILL GO NO FARTHER. BEGINNING IN FY 1984, MANY PROGRAMS IN THE 50 STATES AND U.S. TERRITORIES WILL CLOSE THEIR DOORS, IN A TIME WHEN THESE PROGRAMS ARE NEEDED THE MOST - DURING AND IMMEDIATELY FOLLOWING A PERIOD OF HIGH UNEMPLOYMENT. STATE REVENUES ARE NOT AVAILABLE TO BRIDGE THIS FUNDING GAP SINCE STATE COFFERS ARE BEING DRAINED BY THE PROVISION OF MINIMAL WELFARE AND SOCIAL SERVICES BENEFITS TO THE UNEMPLOYED AND THEIR FAMILIES.

IN THE STATE OF MICHIGAN, THE LARGEST INCREASE IN CLIENT ADMISSIONS HAS COME FROM THE CATEGORY OF THOSE "UNEMPLOYED AND IN THE WORK FORCE," MEANING THOSE RECENTLY LAID OFF AND LOOKING FOR WORK. OVERALL, 63 PERCENT OF THE 75,600 CLIENTS ADMITTED TO PUBLICLY FUNDED SUBSTANCE ABUSE PROGRAMS IN FISCAL YEAR 1982 WERE UNEMPLOYED — AN INCREASE OF MORE THAN 10,000 FROM FY 1978-79. AS IN NEW YORK, HOWEVER, THERE ARE NO ADDITIONAL RESOURCES AVAILABLE TO SUPPORT THE INCREASED DEMAND FOR SERVICES. HUNDREDS OF CLIENTS ARE BEING FORCED TO WAIT FOR SERVICES.

SURVEY OF STATES

IF WE MAY, WE WOULD LIKE TO PROVIDE YOU WITH THE RESULTS OF A SURVEY CONDUCTED BY NASADAD LAST MARCH ON THE STATUS OF STATE ALCOHOL AND DRUG ABUSE SERVICES SYSTEMS. IN THE SURVEY OF THE NASADAD MEMBERSHIP, EACH STATE AGENCY DIRECTOR WAS ASKED TO PROVIDE A NARRATIVE DESCRIPTION OF ANY SIGNIFICANT CHANGES IN THE DELIVERY OF PREVENTION AND/OR TREATMENT SERVICES OVER THE PAST YEAR. STATE DIRECTORS WERE THEN ASKED TO OFFER PROJECTIONS ON FUTURE STATE (NOT FEDERAL) RESOURCES. A BRIEF STATE-BY-STATE SUMMARY OF THE COMMENTS MADE IN RESPONSE TO BOTH OF THESE QUESTIONS IS ATTACHED FOR YOUR INFORMATION.

In general, the comments made by the State agency directors reflect the uniqueness of the States and their service needs. Many of the States have increased their expenditures for prevention programs, a change which appears to be related to the ADMS block grant requirement that 20 percent of the ADMS Block Grant dollars be allocated for prevention, while in other States the directors have independently decided to increase prevention services using State monies. In many States (eleven).the capacity to support treatment services declined in FY 1983; even though the perceived need in those States had increased due to economic conditions. In several States, there has been a change in the type of treatment services provided, with less chronic and/or institutional care and more early intervention type care.

Regarding FY 1984 State monies for alcohol and drug abuse services, the majority of States expressed hope that they would be able to maintain their current level of services for at least part of the Fiscal Year, only seven States indicated that they expected to receive funding increases in FY 1984. In these instances, the projected increases seem to be related to expected alcohol tax increases, to commitments related to drunk driving programming and/or to the expansion of prevention programs. Ten States indicated that they expect to suffer significant reductions in funding in FY 1984.

Of greater importance is the fact that over 94 percent of the States responding to the NASADAD survey reported that an unmet need for treatment and prevention services exists within their State. Thus, even though the State may be able to maintain current service levels, it is not enough — there are still thousands of individuals who need and could benefit from some type of prevention or treatment services.

RECOMMENDATIONS

NASADAD APPLAUDS THE MEMBERS OF THE SELECT COMMITTEE FOR THEIR ASSERTIVE APPROACH TO EXAMINING THE PROBLEMS ASSOCIATED WITH ILLICIT DRUG USE AND CONTROL AND THE EFFECTIVENESS OF THE FEDERAL GOVERNMENT'S ACTIVITIES IN BOTH THE ALCOHOL AND DRUG ABUSE TREATMENT AND PREVENTION SYSTEMS. YOUR ACTIVE INTEREST IN NOT ONLY REDUCING THE AVAILABILITY OF LICIT AND ILLICIT DRUGS, BUT ALSO YOUR CONCERNS FOR HELPING ALCOHOL AND DRUG ABUSERS IS WELCOMED BY THE NATIONAL, STATE AND LOCAL CONSTITUENCY GROUPS, AND EVERYONE WHO HAS EVER ENCOUNTERED THESE PROBLEMS.

IF WE MAY, WE WOULD LIKE TO BRIEFLY OFFER NASADAD'S RECOMMENDATIONS FOR STRENGTHENING THE FEDERAL GOVERNMENT'S ROLE IN REDUCING ALCOHOL AND DRUG ABUSE.

ADMS BLOCK GRANT

NASADAD STRONGLY ENCOURAGES MEMBERS OF THE SELECT COMMITTEE TO SEEK AN APPROPRIATION FOR THE ADMS BLOCK GRANT IN FY 1985 WHICH WILL RETURN THE FEDERAL GOVERNMENT'S FINANCIAL CONTRIBUTION TO ALCOHOL AND DRUG ABUSE TREATMENT AND PREVENTION SERVICES TO ITS PREVIOUS LEVEL. AS MENTIONED EARLIER, FEDERAL SUPPORT FOR THE ALCOHOL AND DRUG SERVICES SYSTEMS HAS DROPPED 40 PERCENT IN RECENT YEARS. STATES ARE SIMPLY UNABLE TO MAKE UP THIS DIFFERENCE AND SHOULD NOT BE EXPECTED TO DO SO. WE ARE AWARE OF THE CHAIRMAN AND OTHER MEMBERS OF THE SELECT COMMITTEE'S EFFORTS TO SECURE FULL FUNDING FOR THE ADMS BLOCK GRANT IN FY 1984 AND APPRECIATE YOUR EFFORTS.

NASADAD ALSO ENCOURAGES THE SELECT COMMITTEE TO SUPPORT THE ADMS BLOCK GRANT AS A FUNDING MECHANISM WHEN IT IS REAUTHORIZED PRIOR TO ITS SEPTEMBER 30, 1984 EXPIRATION DATE AND ASKS THE SELECT COMMITTEE TO SUPPORT AUTHORIZATION LEVELS FOR THE ADMS BLOCK GRANT WHICH RECOGNIZE THE NEED TO SIGNIFICANTLY INCREASE FEDERAL SUPPORT FOR ALCOHOL AND DRUG DEMAND REDUCTION PROGRAMS.

NIDA AND NIAAA

NASADAD ALSO ENCOURAGES THE SUBCOMMITTEE TO RECOGNIZE THE IMPORTANT CONTRIBUTIONS OF THE NATIONAL INSTITUTE ON DRUG ABUSE (NIDA) AND THE NATIONAL INSITUTE ON ALCOHOL ABUSE AND ALCOHOLISM (NIAAA). THE INSTITUTES' RESEARCH PROGRAMS HAVE HELPED US TO BETTER UNDERSTAND ALCOHOLISM AND DRUG ABUSE, ITS CONSEQUENCES, POPULATION GROUPS AT RISK, AND CHANGING PATTERNS AND TRENDS IN DRUG AND ALCOHOL PROBLEMS.

PERHAPS ONE OF THE MOST IMPORTANT FUNCTIONS THAT THE INSTITUTES PROVIDE TO THE STATES, CONGRESS AND OTHERS IS THE IDENTIFICATION OF DRUG ABUSE TRENDS AS WELL AS INFORMATION ON THE INCIDENCE AND PREVALENCE OF ALCOHOL AND DRUG ABUSE DATA, WHICH IS USED BY THE STATES FOR PLANNING PURPOSES. THE NIAAA AND NIDA DATA COLLECTION SYSTEMS' SUCCESS IN THE PAST, HOWEVER, WAS BASED ON THE FACT THAT STATES AND LOCAL PROGRAMS WERE REQUIRED TO PARTICIPATE IN THESE DATA COLLECTION EFFORTS AS A CONDITION OF RECEIPT OF FEDERAL FUNDS. WITH THE AUTHORIZATION OF THE ADMS BLOCK GRANT PROGRAM, THESE REQUIREMENTS WERE ELIMINATED. WHILE THE STATES CONTINUE TO VIEW A NATIONAL CLIENT LEVEL DATA SYSTEM, SUCH AS THE NIDA CODAP SYSTEM, AS A USEFUL AND NECESSARY TOOL FOR ALLOCATING RESOURCES, MANY STATES DO NOT HAVE THE RESOURCES NECESSARY TO SUPPORT THE CONTINUANCE OF SUCH A SYSTEM AT THE STATE LEVEL. AS A RESULT, ONLY 50% OF THE STATES HAVE BEEN ABLE TO CONTINUE COLLECTING AND REPORTING CODAP DATA TO NIDA. THE RESULTING GAP IN KNOWLEDGE AT THE NATIONAL LEVEL HAS SERIOUSLY HAMPERED NIDA'S ABILITY TO MEASURE THE EXTENT OF REGIONAL AND LOCAL DRUG ABUSE TRENDS AND TO ANSWER QUESTIONS SUCH AS HOW MANY DRUG ABUSERS ARE RECEIVING TREATMENT.

A UNIFIED, NATIONAL DATA SYSTEM REQUIRES FEDERAL COORDINATION AND FINANCIAL SUPPORT. BECAUSE OF THE REDUCED LEVEL OF FEDERAL SUPPORT FOR ALCOHOL AND DRUG TREATMENT SERVICES, MANY STATES HAVE HAD TO REALLOCATE FUNDS PREVIOUSLY TARGETED FOR INFORMATION COLLECTION EFFORTS TO THE

PROVISION OF BASIC TREATMENT SERVICES. NASADAD RECOGNIZES THE IMPORTANT ROLE WHICH COMPREHENSIVE NATIONAL DATA COLLECTION SYSTEMS PLAY IN FEDERAL AND STATE POLICY DEVELOPMENT AND ENCOURAGES THE FEDERAL GOVERNMENT TO ASSIST STATES IN THEIR EFFORTS TO CONTINUE COLLECTING DATA.

WE WOULD ALSO LIKE TO BRING TO YOUR ATTENTION AN ACTION PLAN FORMALLY ENDORSED BY THE ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION (ADAMHA) AND THE OFFICE OF JUVENILE JUSTICE AND DELINQUENCY PREVENTION (OJJDP) TO ADDRESS THE NEEDS OF SUBSTANCE ABUSING, MENTALLY ILL JUVENILE OFFENDERS. THE ADMINISTRATORS OF ADAMHA AND OJJDP HAVE PLACED A HIGH PRIORITY ON INCREASING THEIR RESPECTIVE AGENCIES' DEVELOPMENT OF JOINT PROGRAM INITIATIVES FOR THIS TARGET POPULATION. MEMBERS OF CONGRESS HAVE ALSO EXPRESSED CONCERN OVER "THE INCREASING NUMBERS OF YOUNG PEOPLE WHO ARE ADDICTED TO OR WHO ABUSE ALCOHOL AND OTHER DRUGS" AND THE JUVENILE JUSTICE SYSTEM'S "LACK OF OTHER TECHNICAL EXPERTISE AND SUFFICIENT RESOURCES" TO MEET THE NEEDS OF THIS POPULATION.

ACTIVITIES WHICH WILL BE JOINTLY UNDERTAKEN BY ADAMHA AND OJJDP INCLUDE THE CONVENING OF TWO "STATE-OF-THE-ART" CONFERENCES ON THE ALCOHOL, DRUG ABUSE AND/OR MENTAL DISORDERS ASSOCIATED WITH JUVENILE DELINQUENCY. THE FIRST CONFERENCE WILL REVIEW EXISTING RESEARCH ON THE IDENTIFICATION AND UNDERSTANDING OF SUBSTANCE ABUSING, MENTALLY ILL MULTIPLE PROBLEM JUVENILE DELINQUENTS, SEEK TO IDENTIFY RESEARCH NEEDS AND PROPOSE A PLAN FOR TECHNOLOGY TRANSFER. A SECOND JOINTLY SPONSORED CONFERENCE WILL EXAMINE MODELS AND STRATEGIES FOR IDENTIFYING AND REFERRING THIS POPULATION FOR TREATMENT. IN ADDITION TO THE TWO CONFERENCES, OTHER PROPOSED ACTIVITIES INCLUDE: INCREASED FUNDING FOR THE JOINTLY SPONSORED UNIVERSITY OF CHICAGO SURVEY OF RESIDENTIAL FACILITIES AND NON-RESIDENTIAL RESOURCES IN ORDER TO OBTAIN ADDITIONAL ANALYSES OF DATA ON THE TARGET POPULATION AND involving the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Mental Health (NIMH) in the NIDA/OJJDP joint venture on violent substance abusing offenders.

Criminal Justice

Related criminal justice legislative issues which NASADAD encourages the Select Committee to support include the criminal justice block grant authorized by the Justice Assistance Act of 1983, H.R. 2175, authorization of a grant-in-aid program to assist States in developing integrated and effective prescription drug diversion programs as included in Title VII, Part B of the Comprehensive Crime Control Act of 1983, H.R. 2151, and the concept of civil forfeiture as included in H.R. 3299, the Comprehensive Drug Penalty Act of 1983.

NASADAD strongly supports the concept of a Block Grant program to States for the purpose of carrying out programs of proven effectiveness or which offer a high probability of improving the functions of the criminal justice system as proposed by the Justice Assistance Act. Many States have been intimately involved with the highly successful Treatment Alternatives to Street Crime (TASC) program which is one of the specified categories of criminal justice programs which can be funded under this Block Grant program. The TASC program seeks to develop linkages between the criminal justice and alcohol and drug treatment systems as well as reduce recidivism among drug or alcohol abusing offenders. Federal support for programs such as TASC must continue if we are to continue to adequately address the needs of this population which is responsible for a significant portion of property crime in our cities.

NASADAD ENCOURAGES THE SELECT COMMITTEE TO RECOGNIZE THE NEED FOR THE FEDERAL GOVERNMENT TO FOCUS MORE INTENTLY ON THE PROBLEM OF DIVERSION AND ABUSE OF PRESCRIPTION DRUGS. UNDER CONSIDERATION FOR SOMETIME HAS BEEN A GRANT-IN-AID PROGRAM IN DEA TO ASSIST STATES TO DEVELOP INTEGRATED AND EFFECTIVE DIVERSION CONTROL PROGRAMS. NASADAD STRONGLY ENCOURAGES THE SELECT COMMITTEE TO ACTIVELY SEEK AUTHORIZATION OF SUCH A PROGRAM WHICH WOULD PROVIDE INCENTIVES TO STATES TO EVALUATE THEIR DIVERSION PROBLEMS AND DEVELOP STRATEGIES FOR IMPROVING THEIR RESPONSE. AN AUTHORIZATION OF $3-$4 MILLION FOR THIS GRANT PROGRAM WOULD PERMIT AWARDS RANGING FROM $50,000 - $75,000 TO BE MADE TO ALL STATES SEEKING TO IMPLEMENT A COMPREHENSIVE, WELL-COORDINATED, INTERAGENCY RESPONSE TO PRESCRIPTION DRUG DIVERSION. PLANNING AND IMPLEMENTING A STATEWIDE DIVERSION CONTROL PROGRAM IS NOT AN EASY TASK SINCE THERE ARE NUMEROUS AGENCIES WHICH HAVE PARTIAL RESPONSIBILITY FOR DIVERSION CONTROL EFFORTS, AGENCIES WHICH OFTEN OPERATE INDEPENDENT OF EACH OTHER. ONCE AN EFFECTIVE PRESCRIPTION DRUG DIVERSION PROGRAM IS IN PLACE, HOWEVER, THE POSITIVE RESULTS ARE IMMEDIATE. THE DRUG ENFORCEMENT ADMINISTRATION SHOULD ALSO BE ENCOURAGED TO DEVELOP A PROGRAM OF TECHNICAL ASSISTANCE TO STATES INCLUDING ASSIGNMENT OF NEW FIELD OFFICE PERSONNEL TO SERVE AS A PROACTIVE LIAISON TO STATE LICENSING, REGULATORY AND ENFORCEMENT AGENCIES.

WE WOULD ALSO ASK THE SUBCOMMITTEE TO CONSIDER SUPPORTING THE INCLUSION OF LANGUAGE IN THE CIVIL FORFEITURE PROVISION OF THE COMPREHENSIVE DRUG PENALTY ACT OF 1983 WHICH WOULD PERMIT A PORTION OF FUNDS COLLECTED BY AUTHORITIES UNDER THIS PROVISION TO BE ALLOCATED FOR DRUG ABUSE TREATMENT SERVICES. NASADAD ENDORSES THE CONCEPT THAT ASSETS AND PROFITS DERIVED FROM ILLEGAL DRUG TRAFFICKING SHOULD BE UTILIZED, IN PART TO SUPPORT ACTIVITIES IN THE AREA OF DRUG ENFORCEMENT. HOWEVER, IT IS JUST AS APPROPRIATE FOR A PORTION OF THE SEIZED ASSETS TO PROVIDE ADDITIONAL TREATMENT CAPACITY FOR DRUG ADDICTS AND ABUSERS.

TREATMENT PROGRAMS FOR ALCOHOL AND DRUG ABUSERS LACKING PRIVATE OR THIRD PARTY COVERAGE RELY HEAVILY ON FEDERAL AND STATE GOVERNMENT RESOURCES. WITH THE CURRENT REDUCED LEVEL OF FEDERAL SUPPORT, QUITE OFTEN IT IS THE ALCOHOLIC OR DRUG ADDICTED CRIMINAL OFFENDER WHO DOES NOT RECEIVE THE APPROPRIATE TREATMENT. WE BELIEVE THE ENACTMENT OF LEGISLATION AUTHORIZING THE CRIMINAL JUSTICE BLOCK GRANT CAN PLAY AN IMPORTANT ROLE IN IMPROVING SERVICES FOR THIS POPULATION, AS COULD LEGISLATION PERMITTING A PORTION OF FUNDS AND ASSETS SEIZED THROUGH CIVIL FORFEITURE LEGISLATION TO BE DEDICATED TO TREATMENT OF DRUG ABUSE PROBLEMS, EASING SOME OF THE DEMANDS PLACED ON OUR SERVICES SYSTEMS.

FOOD STAMPS

NASADAD ALSO ENCOURAGES THE SELECT COMMITTEE TO SEEK AN AMENDMENT TO THE FOOD STAMP ACT OF 1977 WHICH WOULD PERMIT RESIDENTS OF "PUBLICLY-OPERATED", NON-PROFIT RESIDENTIAL ALCOHOL AND DRUG TREATMENT PROGRAMS TO PARTICIPATE IN THE FOOD STAMP PROGRAM.

AS A RESULT OF A RECENT INTERPRETATION OF THE FOOD STAMP ACT, MANY STATE-APPROVED RESIDENTIAL ALCOHOL AND DRUG PROGRAMS PARTICIPATING IN THE FOOD STAMP PROGRAM HAVE BEEN RE-EVALUATED BY REGIONAL DEPARTMENT OF AGRICULTURE STAFF TO DETERMINE THEIR EILGIBILITY TO CONTINUE TO RECEIVE FOOD STAMPS ON BEHALF OF THEIR CLIENTS. MANY OF THESE PROGRAMS HAVE SINCE BEEN DENIED PARTICIPATION IN THE FOOD STAMP PROGRAM BECAUSE THEY ARE "PUBLICLY-OPERATED" AS OPPOSED TO THE "PRIVATE, NON-PROFIT ORGANIZATIONS" PERMITTED BY THE HOUSEHOLD ELIGIBILITY SECTION OF THE FOOD STAMP ACT. THE PROGRAMS DENIED PARTICIPATION IN THE PROGRAM PROVIDE THE SAME TYPES OF SERVICES AND ARE FUNDED THROUGH THE SAME MECHANISMS AS THE PRIVATE, NON-PROFIT AGENCIES APPROVED TO RECEIVE FOOD STAMPS.

According to the Food Stamp Act of 1977, as amended, only residents of private, non-profit residential alcohol and drug treatment programs may participate in the Food Stamp Program. When determining eligibility, the program must meet three criteria: the center must be 1) certified by the State alcohol and drug agency, 2) operated by a private institution or organization and 3) non-profit. The Department of Agriculture's Food and Nutrition Services (FNS) staff have stated that the source of funding is not the issue when determining whether a program is "private", rather the distinction is who operates the center. For example, in Mississippi, community mental health centers previously authorized to receive food stamps on behalf of their alcohol and drug residential clients, were informed of their termination from the program when the FNS regional food stamp office ruled that the designated regional commissions operating alcohol and drug programs through community mental health centers were public agencies. The community mental health centers' battered womens shelters and disabled centers were, however, permitted to continue to receive food stamps on behalf of their clients.

It is generally believed that the statutory definition of residential alcohol and drug programs was restricted to private, non-profit programs in order to prohibit the participation of State mental hospital programs. Other programs eligible to receive food stamps on behalf of their clients, such as shelters for battered women and group living arrangements for the blind and disabled are not restricted to private, non-profit programs and include public, non-profit organizations in their eligibility criteria.

Senator Thad Cochran temporarily remedied the problem for publicly-operated mental health centers by including in the FY 1984 Senate Agriculture Appropriations legislation language permitting alcohol and

DRUG ABUSE TREATMENT PROGRAMS OPERATED BY COMMUNITY MENTAL HEALTH CENTERS TO BE ELIGIBLE TO RECEIVE AND REDEEM FOOD COUPONS ON BEHALF OF THEIR ELIGIBLE RESIDENTS. SENATOR COCHRAN'S AMENDMENT IS WELCOMED BY ALCOHOL AND DRUG CONSTITUENCY GROUPS, BUT IS LIMITED IN ITS IMPACT AT A NATIONAL LEVEL SINCE PUBLICLY-OPERATED PROGRAMS, OTHER THAN COMMUNITY MENTAL HEALTH CENTERS, WOULD STILL BE DENIED ELIGIBILITY. ALSO, SENATOR COCHRAN'S AMENDMENT ONLY PROVIDES RELIEF TO COMMUNITY MENTAL HEALTH CENTERS FOR THE 1984 FEDERAL FISCAL YEAR.

MEDICARE

NASADAD ALSO ENCOURAGES THE SELECT COMMITTEE TO SEEK PASSAGE OF AMENDMENTS TO TITLE XIX OF THE SOCIAL SECURITY ACT, WHICH WOULD PERMIT FEDERAL REIMBURSEMENT FOR ALCOHOL AND DRUG TREATMENT SERVICES IN FREE-STANDING, NON-HOSPITAL FACILTIES. IN 1980, CONGRESS ENACTED LEGISLATION PERMITTING MEDICARE REIMBURSEMENT FOR ALCOHOLISM DETOXIFICATION SERVICES PROVIDED IN NON-HOSPITAL SETTINGS. HOWEVER, PRIOR TO ITS IMPLEMENTATION, THE AUTHORITY FOR IMPLEMENTING THE REIMBURSEMENT POLICY WAS ELIMINATED AS A BUDGET REDUCING MEASURE. CURRENTLY, MEDICARE REIMBURSEMENT FOR ALCOHOL AND DRUG TREATMENT SERVICES IS ONLY PERMITTED WHEN THE SERVICES ARE PROVIDED IN A HOSPITAL SETTING.

WHILE THE SERVICES PROVIDED IN HOSPITAL SETTINGS ARE OF THE SAME HIGH QUALITY AS SERVICES PROVIDED IN NON-HOSPITAL SETTINGS, THE HOSPITAL SERVICES TEND TO BE SIGNIFICANTLY MORE EXPENSIVE THAN THOSE PROVIDED BY A FREE-STANDING FACILITY. BY PROVIDING REIMBURSEMENT FOR ALCOHOLISM AND DRUG SERVICES IN NON-HOSPITAL FACILITIES, THE FEDERAL GOVERNMENT WOULD BE ABLE TO SIGNIFICANTLY REDUCE THE COST TO MEDICARE OF PROVIDING THESE NECESSARY SERVICES.

WE ENCOURAGE THE MEMBERS OF THE SELECT COMMITTEE TO ALSO ADDRESS THIS ISSUE AND TO WORK WITH THE RELEVANT HOUSE COMMITTEES TO SEEK PASSAGE OF AMENDMENTS TO THE SOCIAL SECURITY ACT WHICH WOULD RECOGNIZE THE APPROPRIATE, LOW COST, QUALITY ALCOHOL AND DRUG TREATMENT SERVICES PROVIDED BY FREE-STANDING, NON-HOSPITAL FACILTIES.

ON A RELATED ISSUE, NASADAD HAS EXPRESSED SERIOUS CONCERNS WITH REGARD TO SPECIFIC SECTIONS OF THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) INTERIM FINAL RULE FOR IMPLEMENTING PROSPECTIVE PAYMENTS FOR MEDICARE INPATIENT HOSPITAL SERVICES. WHILE NASADAD CERTAINLY SUPPORTS HEALTH CARE COST CONTAINMENT EFFORTS, BASED ON THE EXPERIENCE OF OUR MEMBERS, WE HAVE STRONGLY RECOMMENDED THAT HCFA RE-EVALUATE THE PROPOSED RATES SET FOR DRUG AND ALCOHOL TREATMENT SERVICES PROVIDED IN A HOSPITAL SETTING.

FOR EXAMPLE, THE PROPOSED RULE SETS REIMBURSEMENT FOR ALCOHOL DEPENDENCE PROVIDED IN AN URBAN HOSPITAL AT $2,512 BASED ON GEOMETRIC MEAN LENGTH OF STAY OF 8.1 DAYS. BASED ON NASADAD'S EXPERIENCE, THESE FIGURES DO NOT CORRESPOND WITH THE ACTUAL ACCEPTED PRACTICE OF QUALITY ALCOHOLISM TREATMENT FACILITIES. IF THE PROPOSED RATE IS MEANT TO APPLY ONLY TO DETOXIFICATION SERVICES PROVIDED IN AN ACUTE CARE HOSPITAL SETTING, IT MAY BE TOO HIGH. ON THE OTHER HAND, IF THE PROPOSED RATE IS MEANT TO APPLY TO A COMPREHENSIVE TREATMENT REGIMEN PROVIDED IN A HIGHLY ORGANIZED, THERAPEUTIC HOSPITAL PROGRAM SETTING, IT IS MUCH TOO LOW.

OUR MAIN CONCERN, HOWEVER, IS THAT THE REIMBURSEMENT RATES SET FOR THESE SERVICES UNDER THE MEDICARE PROGRAM MIGHT BE EVENTUALLY EXTENDED TO COVER MEDICAID CLIENTS AND EVEN THAT PRIVATE INSURERS MAY CONSIDER THESE PROPOSED LEVELS AS APPROPRIATE LIMITS FOR REIMBURSEMENT OF ALCOHOL AND DRUG TREATMENT SERVICES.

In closing, we encourage the Subcommittee to recognize that the publicly-funded alcohol and drug abuse services programs which rely on Federal and State funds remain effective providers of low cost, quality services. However, without an increase in Federal support, at least to its previous level, we expect to see a gradual deterioration of the alcohol and drug abuse services systems in some parts of the country within the coming year. We would like to once again express our appreciation and the appreciation of our fellow State alcohol and drug abuse directors for your active interest in seeking ways to build upon the Federal-State partnership in the alcohol and drug abuse fields.

Thank you.

ALABAMA:	Treatment: reduced dollars for inpatient & outpatient services. Prevention: doubled dollars and services
ALASKA:	No major changes - under Block Grant continued programs funded by Feds.
ARIZONA:	Alcohol: more early intervention & less chronic care. Drug: expanding methadone maintenance & registering prevention service clients.
ARKANSAS:	Need to expand outpatient & residential alcohol treatment by 80%. Need education on cocaine. Need more attention to DWI & other alcohol related arrests; need more residential drug treatment for youth.
CALIFORNIA:	Are cutting State Operations Staff by 50% (200 to 100 persons), but treatment and prevention are OK.
COLORADO:	DWI evaluation/referral & treatment was transferred from highway office to SAA.
CONNECTICUT:	Active movement to more social setting detoxification; also active in areas of Parent Youth Professional Conferences, DWI Task Force, & shelter/alcohol services for homeless.
DELAWARE:	No major changes due to overlapping and carry over dollars.
FLORIDA:	More group counseling (& less individual counseling); some cuts in client services.
HAWAII:	Treatment programs are struggling to stay open.
ILLINOIS:	Alcohol: focus is on services in community settings rather than in State facilities. Drug: treatment capacity has been reduced due to funding cuts and a decision to increase the slot reimbursement rate to bring it closer to actual costs; have increased support for prevention programs.
INDIANA:	FY 83 dollars up 20% over FY 82 due to use of overlapping funding dollars and State dedicated tax dollars (passed in 1981); expanded all services.
IOWA:	Not much change, although some increase in prevention services.
KENTUCKY:	Replaced grant mechanism with a fee for service system. Increased emphasis on primary prevention.
LOUISIANA:	New DWI legislation effective 1/1/83, but do not yet know its impact on service demand.
MAINE:	New premium law on alcoholic beverages resulted in increased dedicated revenues for alcohol services and mandated interdepartmental cooperation. Have increased levels of both treatment and prevention including both services to institutionalized substance abusers and prevention directed to younger earlier stage drinkers.

---

* From NASADAD survey of membership conducted March 1983. Please note this is a brief Summary of a much more extensive narrative provided by the States.

Changes in Status of Services Systems in FY 1983 (cont'd.)

MARYLAND:	Block Grant led to increased dollars for prevention. Also have implemented Statewide EAP.
MASSACHUSETTS:	Use Block Grant process to cut poor performing programs and fund improved programs more responsive to needs, e.g., for minorities & Hispanics. Used overlap dollars to extend services over time; Block Grant is a grand idea and preferable to direct Federal funding of local programs.
MICHIGAN:	Substance abuse programs & staff have been cut. Client waiting lists are up; more clients are unemployed.
MINNESOTA:	Have experienced funding cutbacks, especially for public clients (e.g., in medical assistance), now send clients to State hospitals.
MISSISSIPPI:	Some cuts in funding.
MISSOURI:	Adopted comprehensive services model & service area planning/resource allocation concept; transition from State hospitals to community based programs and services.
MONTANA:	Have maintained services at level prior to Block Grant funding.
NEVADA:	Using newly available alcohol excise tax monies earmarked for substance abuse services. Civil Protective Custody and Detoxification Services have been expended in some parts of the State. Due to the Block Grant requirement some programs have refocused their activities from treatment to prevention, resulting in a decrease in the number of treatment slots available. Due to the economic recession, Federal funding cutbacks and shrinking alternative funding sources, many alcohol and drug treatment and prevention programs are operating at extremely critical financial levels.
NEW JERSEY:	Due to funding cutbacks some programs have been reduced in size or closed. However, two small new programs have been opened to serve financially and medically indigent women.
NEW MEXICO:	Over past year treatment service needs increased 35% and prevention service needs increased 50%.
NEW YORK:	Drug: Lost 32% Federal dollars in transition to Block Grant therefore have fewer dollars at a time of increasing need; looking to alternative financing through private health insurance, EAPs, etc. Alcohol: The past year has been a significant one for alcoholism services. New legislation related to drunk driving has resulted in the availability of fine money as a match for State administered funds on a 50/50 basis. The new Governor, Mario M. Cuomo, in his State of the State Message announced his intent to introduce and strongly support legislation mandating insurance coverage for alcoholism services. Governor Cuomo also highlighted employee assistance programs and prevention services as priorities for his administration.
NORTH CAROLINA:	Funding has remained relatively stable although it has not kept pace with inflation.
NORTH DAKOTA:	Became more active in prevention programming [illegible]

Changes in Status of Services Systems in FY 1983 (cont'd.)

OHIO:	Drug: Lost Federal dollars in Block Grant, Title XIX & XX reductions & also State unemployment & deficits leading to State deficits leading to State dollar reductions; therefore have consolidated & merged programs, combined alcohol & drug programs; developed more EAPs, decreased services provided, length of treatment & number of clients served; have wider range of prevention services. Alcohol: increases in private hospital based programs & youth prevention programs.
OKLAHOMA:	More concentration on treatment services for youth & adolescents & on prevention services.
OREGON:	Major change has been to support services on a slot funding basis. Also closed the alcohol & drug ward at Oregon State Hospital & moved intensive services to a nonhospital setting.
PENNSYLVANIA:	Used forward funding of grantees to ease 25% Federal funding cut; made 15% cut in period ending 6/83; stable 7/83 to 6/84, & project 10% additional cut in 7/84 to 6/85.
RHODE ISLAND:	Need has increased due to unemployment & DWI referrals; waiting lists are longer, but have fewer dollars available to meet the needs.
SOUTH CAROLINA:	Due to revenue shortfalls State FY 83 monies were reduced by 9%, but programs were not reduced; used Block Grant monies to expand prevention services and programs.
TENNESSEE:	Two significant changes: (1) notable increase in prevention funding plus targetting to areas of Fetal Alcohol Syndrome early intervention with high risk youth, & teacher training; (2) shift of detoxification & intensive residential services from institutional to community based programs.
TEXAS:	Drug: Major expansion of prevention services especially for at risk youth; also decrease in treatment services (6% since FY 82 & 11% since FY 81).
UTAH:	Significant increase in funding for prevention programs; also implemented a Public Inebriate Program including $1.5 million in earmarked monies from alcohol tax increases.
VERMONT:	Doubled State support for prevention activities. Reduced support for some treatment programs due to Block Grant cut.
VIRGINIA:	Support community based programs, citizen involvement, & interface between treatment & criminal justice systems.
WASHINGTON:	Experienced major cuts in FY 83 (e.g., 37% in drug outpatient services. Also major cuts in education, prevention, training & project grants). Block grant mechanism did not have a major impact although did expend some dollars differently.

Changes in Status of Services Systems in FY 1983 (cont'd.)

WEST VIRGINIA: State Supreme Court ruled that incarceration of chronic alcoholic for public intoxication is illegal and State must provide appropriate care. State and community behavioral health centers reallocated dollars to provide 24 hour screening, medical referral and shelter care.

WISCONSIN: A major reorganization has taken place within the State agency, resulting in a significant reduction in staff.

WYOMING: With State dollars increase of about 25 percent, residential treatment services were increased.

ATTACHMENT 2

Projections for State Monies in FY 1984

ALABAMA:	Hope for stable funding in FY 1984; do not expect to obtain requested increase.
ALASKA:	In FY 1984 expect 2½ million cut in State monies (16%) and will have to eliminate programs.
ARIZONA:	Expect significant reductions in FY 1984 State dollars (7 to 17%).
ARKANSAS:	Expect 7% increase for treatment to cover inflation costs. Are no general revenue State dollars for prevention services.
CALIFORNIA:	Expect stable Federal and State dollars for local programs, but don't know of county dollar level.
COLORADO:	In FY 1984, expect a maintenance level budget.
CONNECTICUT:	Expect at least stable funding plus 5.8% increase for community grants, and if tax bill passes, could receive $1.5 million.
DELAWARE:	In FY 1984 will reduce number of programs (but costs not due to dollars); expect major dollar problems in FY 1985.
DISTRICT OF COLUMBIA:	Have requested a major funding increase, but don't know whether it will be granted.
FLORIDA:	Some overall cuts in alcohol services, although more dollars for DWI & residential youth alcohol treatment; expect some increases in drug abuse services.
HAWAII:	Expect a slight decrease in State monies in FY 1984.
IDAHO:	Expect a decrease in State monies in FY 1984 of $300,000, but will try to reduce the impact of this cut in services through faster utilization of Block Grant monies; crunch will come in late 1984 or 1985.
ILLINOIS:	Alcohol: expect some funding cuts in FY 1984. Drug: in FY 1984 the budget will probably remain at about the current reduced level.
INDIANA:	Expect FY 1984 budget increase of 13%; will expand court alcohol and drug services programs by 50% in 2 years; priorities are youths residential treatment and youth prevention and early intervention.
IOWA:	Future is difficult to project; probably will be stable although could be some reductions, or if dedicated tax is passed, some increases.
KENTUCKY:	Expect status quo for FY 1984 State service funding.

Projections for State Monies in FY 1984 (cont'd.)

LOUISIANA:	Expect budget cut of approximately 15% & further reorganization & consolidation of clinical facilities to cut costs.
MAINE:	Some new monies may be authorized, but they may be offset by declining alcohol sales and premium revenues.
MARYLAND:	Expect stable funding with exception of increase in outpatient services related to comprehensive DWI program.
MASSACHUSETTS:	Expect at least stable funding & possibly some increases. (Alcohol agency); hoping for stable funding (Drug agency).
MICHIGAN:	Hope for stable funding levels, with increased State taxes, insurance dollars, DWI fees, etc.
MINNESOTA:	Hope for stable funding.
MISSOURI:	Hope to work with General Assembly to generate resources required to meet needs.
MONTANA:	Expect funding to remain stable (have earmarked alcohol tax dollars going to counties).
NEBRASKA:	Expect no increase in State dollars; problems will occur in FYs 85 & 86 once carryover funds are depleted (programs may have to be cut 20 to 30%).
NEVADA:	State General Fund appropriations over the period FY 1983 - FY 1985 have been cut substantially.
NEW HAMPSHIRE:	If the initial budget is adopted services will be cut, but if alternative funding measures pass then services could be increased.
NEW JERSEY:	Hope to maintain current funding level and support existing programs.
NEW YORK:	Alcohol: Expect continuation of current level of State support. Drug: Proposed State budget projects stable State funding but cannot make up Federal funding cuts concurrent with Block Grant implementation therefore are experiencing cuts at a time of expanding needs.
NORTH CAROLINA:	In FY 83-84 expect stable funding but will transfer dollars from institutions to communities for alcohol services.

Projections for State Monies in FY 1984 (cont'd.)

NORTH DAKOTA:	Don't know, but hope for stable funding in FY 1984.
OHIO:	Drug: Hope to obtain maintenance level of funding, including more State dollars to make up for loss of Federal dollars.
OKLAHOMA:	Due to declining tax revenues (oil glut) expect cuts of about 6% in State support.
OREGON:	Expect to maintain current level of services & funding in FY 1984.
PENNSYLVANIA:	Hope for stable funding in FY 84.
RHODE ISLAND:	Expect some cuts in State dollars that will lead to service cuts at a time when needs are increasing.
SOUTH CAROLINA:	Future funding appears stable, although State & local revenues are most questionable.
TENNESSEE:	Anticipate stable funding in FY 1984.
TEXAS:	Federal funds will be reduced by 28% in FY 1984, but the State is considering major funding increases (e.g., from current level of $210,000 to request of $10,704,690). Budget may decrease slightly; however, if public inebriate and/or DWI legislation is passed, additional State funds would be made available.
UTAH:	Hope for stable funding for treatment, plus $2 million increase for prevention.
VERMONT:	Expect to be able to maintain services at current levels.
VIRGINIA:	Expect budget increase of 10 to 15% in FY 1984.
WASHINGTON:	In FY 1984 expect major State dollar increases & restoration to higher 1982 level. Expect State prevention dollars to double from $850,000 to 1,700,000) and drug outpatient dollars to be restored.
WEST VIRGINIA:	Anticipate major State dollar increase ($2.7 million) for shelters & residential treatment (see Supreme Court ruling - item #6) plus expansion of substance abuse prevention & other services.
WISCONSIN:	Expect continuing decrease in State monies & services due to $2 billion budget deficit.
WYOMING:	Have biennial budget & anticipate 9% inflation increase in FY 1984; don't know about FY 85 (State dollar availability is related to uranium & oil prices).

Boston

TESTIMONY OF PAUL E. ROBINSON,
EXECUTIVE SECRETARY, CITY OF BOSTON
COORDINATING COUNCIL ON DRUG ABUSE,
BEFORE THE SELECT COMMITTEE ON NARCOTICS
ABUSE AND CONTROL, U. S. HOUSE OF
REPRESENTATIVES, WASHINGTON, D.C.,
NOVEMBER 2, 1983

(Mr. Robinson is the Immediate Past
Chairperson, National Association for
City Drug and Alcohol Coordination, Inc.)

Mr. Chairman, Members of the Select Committee, I am Paul E. Robinson, Executive Secretary of the City of Boston Coordinating Council on Drug Abuse and the Assistant Deputy Commissioner for Addictions for the City of Boston Department of Health and Hospitals.

I appreciate the opportunity to appear before you today in response to your kind invitation, to offer you a city's perspective on the implementation of the Administration's 1982 Federal Strategy for the Prevention of Drug Abuse and Drug Trafficking.

In 1971, Boston Mayor Kevin H. White was requested by Chairman Claude E. Pepper of the House Select Committee on Crime to address urban drug abuse concerns. Mayor White observed that drug abuse, as it impacts seriously on major urban centers, is too complex and extensive to be managed solely through the resources of isolated communities. He recommended that federal resources be allocated directly to our nation's major cities to be used for treatment, rehabilitation and prevention, and that this national committment should support a coordinated, comprehensive effort in the reduction of both supply and demand.

In October, 1983, the City of Boston returns to the House of Representatives to appear before another of its distinguished Select Committees, and we renew our request for a genuine committment, from the federal government, to respond to the drug abuse problems in our nation's major cities. The twelve intervening years have seen the continued growth of the use of heroin in our urban streets, and a pharmacopoeia of other drugs, including cocaine, gain increasing popularity in city neighborhoods.

An observer would have to be puzzled if asked to discover a relationship between the text and implementation of the 1982 Strategy, and the testimony of representatives of our major cities to Congress since the early 1970's. Through four Administrations the mayors of our largest cities have been describing the situation on our streets and in our neighborhoods, and have repeatedly explained the cities' resource limitations in mounting the major effort required to provide a respectable public health and safety response to drug, and especially heroin, addiction.

The current federal approach to drug abuse - I hesitate to describe it as a clearly-articulated "Strategy" - is in fact one of rhetorical neglect, punctuated with occasional media-oriented events calciuated to demonstrate photogenic Administration concern for suburban adolescent experimentation with so-called "gateway" drugs.

What we do not see is a genuine effort to support and enable the resource-drained large cities to provide treatment and prevention services to the climbing numbers of heroin and cocaine users who are waiting in lengthening lines to find services from programs which have been forced to reduce programming to compensate for reduced federal funding.

The introduction of the Alcohol, Drug Abuse and Mental Health (ADM) Block Grant serves as a metaphor and an illustration of the self-imposed obstacles this Administration has experienced in mounting an effective response to the urban drug problem. From my viewpoint, that of a large city addiction services administrator, the institution of this block grant ignored a decade of experience with the shortcomings large cities experienced with the previous funding mechanism, and it was apparently conceived and implemented without reference to the cities' own projected need for treatment services during the years immediately ahead.

The public relations effort accompanying the federal government's adoption of the ADM Block Grant stressed theoretical financial savings, as well as administrative benefits for the States, to be derived from a reduced federal role. The Administration asserted that under the ADM structure, resource allocation decisions would be made closer to the service delivery level, assuring new efficiencies.

With respect to the claim of inherent financial savings, the General Accounting Office has studied and accurately reported on its lack of merit. The proposition that a reduced federal role automatically results in more efficient grass roots resource deployment is also without basis, and could have been predicted from the experience of cities under the funding activity through P.L. 92-255. Under this drug abuse services funding mechanism, the National Institute on Drug Abuse (NIDA) decided to rely upon Single State Agencies to establish statewide priorities and to allocate funds, deliberately ignoring any role for local governments. This regularly resulted in the funding of programs and development of services with little or no impact on the State's major drug abuse site, its principal city.

Over time, after presentations from individual cities and from such organizations as the U. S. Conference of Mayors and the National Association for City Drug and Alcohol Coordination, Congress understood the concerns of local government and, in 1978 and 1979, passed legislation requring that the nation's large cities be involved in planning the comprehensive effort to provide treatment and prevention services, finally assuring a genuine federal-state-city partnership to meet a national issue. With the intergovernmental structure finally in place to match the years of rhetoric about a national problem which manifests its destructiveness on a local level, the cities looked forward to making this partnership work, and bring relief to their populations with drug-related problems.

The decision by the federal government to turn to the present, State-administered ADM Block Grants disrupted advances made by cities in becoming participants in developing meaningful statewide strategies in collaboration with their Single State Agencies for Drug Abuse Prevention. The legislation requiring States to solicit and include the input of their large cities with respect to treatment and prevention needs was ignored under the new ADM Block Grant process, proving disruptive to collaborative planning and, in fact, a regression in intergovernmental policy development for drug abuse prevention.

Indeed, not only did the federal government - failing to benefit by experience - establish a funding mechanism which bypasses any systemic or substantive participation of city administrators; it has in fact promulgated even fewer controls to oversee State administration of funds than existed under the previous structure. This reduced State accountability to the federal government is a cause for concern by large cities seeking the means to ensure State agency sensitivity to their urban populations.

An additional cause for the concern of large cities, and one for which Congress - through its power of the purse - must share responsibility with the Administration, is the use of the ADM Block Grant to reduce federal treatment services funding. In Massachusetts, this funding reduction translates into a decrease of $1.5 million between the last year of P.L. 92-255 subsidies, and the current ADM Block Grant allocation. In the Commonwealth, this reduction has forced a decrease in residential drug treatment facilities from 21 to 11, with a corresponding drop in capacity from 500 to 232 beds. Within the City of Boston itself, a clear indication that demand for services is outstripping resources: within one 24-hour period in early September, nine unconcscious persons, addicted to heroin, were brought into Boston City Hospital. Fortunately, with prompt treatment by Emergency Room personnel they recovered . . . but no drug treatment services could be offered, because all the narcotic treatment programs in the city are at capacity. For administrators and clinicians alike, it hurts to have to say - 30 to 40 times each month - "sorry, there's no room" to those seeking treatment and rehabilitation.

This is the reality of the ADM Block Grant, in terms of intergovernmental relationships and in terms of delivery of treatment services. Both of these factors were ignored in the Administration's haste to enact this funding mechanism. And I submit that this block grant structure, in the light of the substance of the 1982 Strategy, is actually a blind rush to flee the field of battle without even stopping to accomodate the casualties which continue to increase in the streets of this nation's major cities.

This Select Committee inquires into the effects of the Administration's 1982 Strategy on demand reduction. Since the implementation of that strategy has been a cutback in support for treatment, rehabilitation and prevention, the results are, quite logically, destructive. The system which has been put into place, never a secure services network due in part to its lack of appeal to the mainstream health care establishment third party funders, has barely managed to hold its own during the past two years. The dedication and ingenuity of administrators and clinicians have, in many surviving programs, delayed the effects of federal funding reductions, but the wear and tear on this human resource is now showing, and I predict an inevitable implosion of services during the next twelve months if federal funding reductions proceed as scheduled.

Although federal administrators seem unable or unwilling to grasp this central fact, certainly Congressional observers, as they return to their communities, must understand that the grandiloquent statements that State and local governments, and private philanthropies, had the resources to compensate for federal budget reductions were unsupported by reality and were simply a self-serving smokescreen to permit a federal-level retreat from a substantive leadership role in a national drug abuse prevention effort.

In short, the ADM Block Grant is serving what I interpret to be the actual intent behind the 1982 Strategy, namely providing a cover for a federal government exit from the drug abuse effort. Due to easily foreseen resource limitations on both State and local governments, the Block Grant funding level is also effectively eroding an already vulnerable treatment system, and its lack of intergovernmental access is again shutting the major cities out of any systemic role in the planning, coordinating and administration of demand reduction programming.

The Select Committee asks for alternatives or improvements to the status quo. Let me offer a range of recommendations and observations, which relate to the 1982 Strategy and to the ADM Block Grant funding mechanism and levels.

First, I would suggest that we need a genuine commitment - not rhetoric and photo opportunities - from an Administration which is capable of discerning the distinction between gestures and substantive development, implementation and maintenance of treatment and prevention programming. We need to move beyond the Orwellian Newspeak that less funding is somehow increased support. We need to penetrate the persiflage of the so-called 1982 Federal "Strategy" and prepare a rationally-evaluated agenda. Unless this commitment can be secured, even the best efforts of this Select Committee and this Congress, and the continued presentations of this nation's mayors and their addiction service coordinators, are not going to matter, and the lines of people waiting for services is going to continue to lengthen.

Along with this commitment to prepare and enact a substantive national effort, involving every level of government, must come the appointment of an executive office-level official, who can balance the roles of supply and demand reduction, who can respect and represent the special needs of cities and their high risk populations, and who can, in the best sense, serve as an advocate, as a coordinator, as a focal point for an administration's commitment to drug abuse prevention. Such a position, and such a person, does not now exist nor would it be meaningful in the current Administration, given the absence of any genuine interest in fulfilling a leadership role for this national concern.

Nevertheless, if the 1982 Strategy were in any sense valid, its implementation would demand the oversight of such an individual with the authority and responsibility to achieve inter-departmental cooperation, as well as intergovernmental collaboration. Again, were the 1982 Strategy to be closely examined in terms of balance between demand and supply reduction emphases, an official in this role would be able to advise the administration that its imbalance toward enforcement activities actually does these programs a disservice by overstating the extent to which they must be held responsible for reducing the prevalence and incidence of drug abuse.

Although I must assume, given its impact, that the ADM Block Grant mechanism is intended by the Administration to enable it to escape its responsibilities in the drug field, I would propose the following modifications to its inherently flawed structure. In its present form it offers no incentive for advance in intergovernmental cooperation for the critical health area of drug abuse. It does not, to any meaningful or explicit extent, provide elected city officials the opportunity to be an integral part of the process for determining needs and priorities as outlined in the State funding application. Ironically, although drug treatment services are activities which, to a disproportionate extent, occur within large city jurisdictions, local officials have little or no participation in assuring their responsiveness to the municipalities. The result of this lack of opportunity for elected city officials to participate effectively in drug policy formation and planning efforts suggests an ongoing insensitivity to the cities' concerns, and to the needs of their diverse populations.

Despite the fact that it is in the larger cities where success of failure of this drug abuse prevention effort will be most evident, the provisions for the block grant ignores the logic that these municipal officials be formally-designated participants in the policy, planning and service delivery process.

The Block Grant mechanism, in fact, leaves the clear impression that cities, and their mayors, are at best irrelevant to the administration of drug abuse treatment funds. Further, there is no evidence that previous indifference to city priorities in this field will change in any appreciable manner, despite the fact that addiction-related problems impact most intensely on the local level. The opportunity for redress, given the almost non-existent federal monitoring role, is lacking for this fundamental issue, which undercuts or supports the medium through which meaningful comment and recommendations can be offered.

It is clear that the most intense problems of drug abuse in Massachusetts, for instance, are concentrated in her largest cities. The social costs of drug abuse, particularly narcotic addiction, are likewise most significant in urban areas. In the latest Drug Enforcement Administration intelligence bulletin for New England, it states that white heroin continues to dominate the area, with purities ranging from 13-18%. Purchases of heroin outside of Boston have dealer logos of "Colt 45" and ".357". One bundle of the ".357" was purchased for $400 and analyzed at 11.4% purity. Cocaine continues to escalate. Ounce quantities of 75-80% purity at $2,100 - 2,200 have been purchased.

Drug abuse in the urban setting has special characteristics and presents social problems and service needs for all segments of the population. City governments are most appropriate for interpreting and coordinating the diverse program efforts required within their jurisdictions. When cities are involved in drug abuse planning and services coordination, the services are most likely to be responsive to the local residents. But when cities are bypassed, an opportunity is missed to develop and render comprehensive services at the primary level of need.

The first ADM Block Grant modification I would recommend would incorporate a flexibility to allow money to be administered at the local government level. Cities, with major concentrations of drug abuse, should be given primary consideration to receive direct grants for the development of comprehensive programs which would include

- health care treatment for addicted persons;
- supportive and aftercare services;
- preventive services, including early intervention for adolescents.

Cities, using a population/need formula, would receive these block grant allocations directly from the federal agency responsible for grant administration, for the development of comprehensive drug treatment and prevention programs.

The second ADM Block Grant revision would address local government participation in planning and developing the State application. The current process should expand to:

- ensure that large cities with the most severe concentrations of drug-related problems be guaranteed the opportunity to adequately review and approve the relevant sections of the State application (not as occurred in Massachusetts this year, when the City of Boston received a two-hour notice to testify on an application we had never seen);
- recognize cities, with major concentrations of drug abuse and with the demonstrated capability, to be the authority to develop and coordinate a sub-state component of the State application. (Major cities have prepared such plans for several years, including the City of Boston.)

Again, these are provisions which Congress explicitly added to the previous drug abuse funding legislation, and required NIDA to monitor the development of annual State Plans to assure that the cities were in fact provided the opportunity for this participation.

It is important to note that not all cities will experience the need nor the capability to respond to drug abuse services planning in the manner outlined in the above recommendations. However, the option for such participation with the designated State authorities will enhance the efforts of both levels of government in addressing drug abuse prevention.

Clearly, if States are to be the sole arbiter of need, then the chances increase that cities will fail to receive the resources in proportion to need; the political realities inevitably lobby State administrations to allocate funds, with diminished effectiveness, on a geographic, rather than a need-for-services, basis. The option for the input of local elected officials, from cities with major drug abuse problems, would serve as a check and balance to this discrepancy.

A third recommendation, to enhance the effectiveness of the ADM Block Grant, would be to strengthen the deliberately weak federal oversight role. It is appropriate for the federal funding agency to serve as the financial and resource allocation monitor, and hence the advocate for the interests of the readily disenfranchised. However, the provisions for this are weakly - if at all - provided within the current legislation.

In addition to responding to your inquiry into the viewpoin of a city on the Federal 1982 Strategy and on the ADM Block Grant, I would also like to address several of the other issues which you have raised with respect to the effects of federal drug abuse policy on large urban governments.

- There are certainly some major gaps in current demand reduction efforts, which are either the result of, or exacerbated by, the significant reduction in federal funding during the past two years. In Boston, and in Massachusetts generally, we need additional treatment services and programs most critically for:

  a) adult women;

  b) male and female adolescents;

  c) inpatient polydrug treatment.

- It must be observed that federal funding reductions are not being compensated in the public sector, due to limitations on the resources of both State and local governments. Need for services has outstripped these budgets.

  In addition, it must be stated that the private sector, either through volunteer staffing or through philanthropic contributions, is not an adequate replacement for the loss of federal dollars to treatment.

- Current program efforts are being reduced to a form of triage, which is eliminating services to some of the most vulnerable clients, as well as removing those types of program efforts, such as effective aftercare, vocational and supportive activities. This almost guarantees recidivism and diminishes efforts in the field to establish cost effective health care goals.

- It is unclear, at this point, exactly what type of assistance cities can seek and secure from the Federal government to assist in planning, coordinating and administering drug abuse programming. Certainly the Federal government has not made a vigorous effort to inform cities of the range of technical assistance available to them, nor how to gain access to it.

  One primary example of how cities might use Federal technical assistance would be for the Federal agency to provide updated information on prevention and treatment program advances, with recommendations for improving effectiveness and efficiency of urban programs.

  Federal-city collaboration in epidemiological forecasting would also prove advantageous to all levels of government.

- The City of Boston's Department of Narcotic Addiction (an agency of the City's Department of Health and Hospitals' Office of Addiction Services) has, during the past two years, developed a 16-20 month detoxification program to treat persons addicted to narcotics, which we feel is an improvement over the short term 21-day detoxification regimen and an advance over the open-ended methadone maintenance modality. I shall be pleased to provide the Select Committee with a summary of this new program's therapeutic activity.

  I am concerned that the limited Federal funding will cause a renewed emphasis on the 21-day detoxification modality, which in itself offers little if any long term therapeutic value. The more intensive programming, such as offered by Boston's Department of Narcotic Addiction, is not going to be developed and implemented unless funding is allocated for that purpose.

In conclusion, I would have to say that I am encouraged by the invitation to appear before you today, and by the types of inquiries which you have made in an effort to determine the effect of the current Federal activity on drug abuse programming in our cities.

However, I must share with you my frustration over the effects of that Federal activity, which I have watched not only as an addiction services coordinator for the City of Boston, but also as the past Chairperson for the National Association for City Drug and Alcohol Coordination. Not too long ago, while I was wearing both of those hats, I engaged the Special Assistant to the President for Drug Abuse Policy in conversation, hoping for some explanation for the Administration's drug abuse policy. I got what I asked for, but I don't think it has much relevance to this country's most serious addiction problem: I was told that heroin addiction is a city problem . . . the federal program emphasis is on suburban adolescents' use of "gateway" drugs.

I appreciate the opportunity to offer these remarks to this Select Committee, Mr. Chairman, in the hope that this Committee, and this Congress, will be instrumental in refocusing the Federal drug abuse effort to address the serious urban addiction problem. Toward this end I make myself available to the Select Committee and its staff, for any additional assistance I might offer. I also commend the Select Committee to systematically call upon the National Association for City Drug and Alcohol Coordination for its perspective on urban-related drug abuse policy concerns.

It would be a mistake for the past years of disenfranchisement of cities in the development and implementation of drug abuse policy to continue, for it weakens the effective response of all levels of government to drug abuse problems. City drug abuse coordinators expect to - even look forward to - collaborating with our counterparts on the State level to guarantee quality service delivery. And we look for genuine leadership and support from our Federal government colleagues. But we must assert that in dealing with these issues at the level where we live, and work, and raise our families, it is our cities which must play an essential role.

TESTIMONY SUBMITTED FOR THE RECORD BY MARK W. PARRINO, CHAIRMAN, NEW YORK STATE COMMITTEE OF METHADONE PROGRAMS ADMINISTRATORS, IN SUPPORT OF THE PRESENTATION BY ARTHUR JAFFE TO THE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

NOVEMBER 2, 1983

Our country is experiencing a period of escalating and profound substance abuse. The devastating impact of marijuana, cocaine, pills and heroin has threatened the integrity of our nation's educational system, industry, military services and law enforcement capabilities.

Thousands of children smoke "grass" as a routine part of their school day. Employees use debilitating drugs at the work place, limiting productivity. The military must train its enlisted to perform complex tasks with sophisticated equipment, in-spite of the high incidence of drug use in the services. Law enforcement is overwhelmed by the crimes that result from the availability of drugs in our communities.

In the face of this critical national problem, the federal government has inexplicably reduced its funding for the alcohol, drug abuse and mental health block grant. I understand that the ADAMHA block grant will be reduced by an additional $30 million for fiscal year 1984.

I do not pretend to understand the rational for these reductions since drug trafficking and substance abuse continue to deprive our nation of a healthy, motivated and clear thinking citizenry.

Methadone Maintenance Programs in New York State are at the brink of organizational dissolution as a direct result of the ever shrinking ADAMHA block grants. The following points should provide some clarity.

1. Existing methadone treatment programs are filled to capacity. Services must remain constrained to treat an expanding patient population with less money.

2. Admission waiting lists to methadone programs are increasing at a significant and alarming rate. Desperate people, who are entrapped by the ravages of heroin abuse, are being denied access to critically needed, but limited health care. This reality poses a considerable health risk to narcotics abusers and the public's health, since they are forced to remain in the septic shooting galleries, where new AIDS cases develop with each hour. Denying/or delaying proven chemotherapeutic treatment to those in need of its beneficial effect is morally unconscionable in our society.

   It is also bad politics. It costs our society more money to keep an individual in jail or out of treatment than it does to provide the required methadone services.

3. The federal government is increasing its interdiction efforts in the arena of international drug trafficking. If these efforts prove to be successful, the available supply of illicit narcotics will be reduced. Narcotics abusers will require access to treatment once their supply of illicit narcotics is cut off. Admission waiting lists to methadone programs will increase to epidemic proportions, as they did during the latter 1960's.

   The value of increased interdiction will be compromised by the dearth of available treatment programs. Narcotics users will be compelled to commit more crimes to raise the money for higher priced heroin, which will be in shorter supply.

   An unbalanced program of increased law enforcement and reduced treatment availability will produce social disorder.

The federal government must develop a more realistic program to contain the escalating substance abuse problem in our nation if we are to provide treatment to those in need of care. We cannot write off the value of thousands of people by reducing block grants that further limit treatment availability. You are being asked to increase the funding level of the ADAMHA block grant to preserve the prevention-treatment continuum. While the flesh of our programs has been considerably eroded, the brittle skeletal structure remains---but not for much longer.

THERAPEUTIC COMMUNITIES of AMERICA

OFFICERS
President
RICHARD PRUSS
Samaritan Village, Inc
1st Vice President
DANIEL HEIT
Abraxas Foundation, Inc
2nd Vice President
MICHAEL DARCY
Gateway Houses Foundation, Inc
Secretary
PENELOPE GROENCHIN
Gaudenzia, Inc
Treasurer
ROBERT SMEDES
Project REHAB

BOARD MEMBER AGENCIES
ABRAXAS FOUNDATION, INC
Pittsburgh, Pennsylvania
ALBA-NECK HALFWAY HOUSE
Hauppauge, New York
AREBA
New York, New York
AURORA CONCEPT, INC
New York, New York
CENIKOR FOUNDATION, INC
Houston, Texas
CURA, INC
Newark, New Jersey
DAMON HOUSE
New Brunswick, New Jersey
DAYTOP VILLAGE, INC
New York, New York
EAGLEVILLE HOSPITAL & REHABILITATION CENTER
Eagleville, Pennsylvania
EDEN HOUSE
Minneapolis, Minnesota
FITZSIMMONS HOUSE, INC
Las Vegas, Nevada
GATEWAY HOUSES FOUNDATION, INC
Chicago, Illinois
GAUDENZIA, INC
Philadelphia, Pennsylvania
GENESIS II, INC
Philadelphia, Pennsylvania
HOUSE OF THE CROSSROADS
Pittsburgh, Pennsylvania
INTEGRITY, INC
Newark, New Jersey
J-CAP
Jamaica, New York
LINWOOD THERAPEUTIC COMMUNITY
Davenport, Iowa
MARATHON HOUSE, INC
Providence, Rhode Island
MY FAMILY, INC
Riverside, California
NEW ARIZONA FAMILY, INC
Phoenix, Arizona
ODYSSEY HOUSE, INC
New York, New York
OPERATION PAR
St. Petersburg, Florida
PEER I
Denver, Colorado
PHOENIX HOUSES FOUNDATION, INC
New York, New York
THE PORTAGE PROGRAMME
Montreal, Quebec, Canada
PROJECT REHAB
Grand Rapids, Michigan
PROJECT RETURN FOUNDATION, INC
New York, New York
PROMESA
New York, New York
RENAISSANCE PROJECT
New Rochelle, New York
SAMARITAN VILLAGE, INC
Forest Hills, New York
SEA-DRU-NAR
Seattle, Washington
SECOND GENESIS, INC
Bethesda, Maryland
SHAR HOUSE
Detroit, Michigan
SPECTRUM HOUSE, INC
North Grafton, Massachusetts
STAY 'N OUT
New York, New York
VERITAS THERAPEUTIC COMMUNITY
New York, New York
THE VILLAGE SOUTH, INC
Miami, Florida
WALDEN HOUSE
San Francisco, California
WOMEN, INC
Dorchester, Massachusetts
YOUTH DRUG PROGRAM
Dayton, Ohio

STATEMENT SUBMITTED FOR THE RECORD BY RICHARD PRUSS, PRESIDENT, THERAPEUTIC COMMUNITIES OF AMERICA, IN SUPPORT OF THE PRESENTATION BY ARTHUR JAFFE, DIRECTOR, SPARK PROGRAM, AND CHAIRMAN, NEW YORK STATE ASSOCIATION OF SUBSTANCE ABUSE PROGRAMS, TO THE HOUSE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL, NOVEMBER 2, 1983

Therapeutic Communities of America, the national consortium of more than 300 drug-free treatment agencies in the U.S. and Canada, fully shares the concerns of SPARK about the "Federal Strategy for Prevention of Drug Abuse and Drug Trafficking." The only targets of this federal offensive should be the drug dealers. Instead, the casualty lists include more and more of our young people.

In fiscal 1980, as the National Association of State Alcohol and Drug Abuse Directors informed Congress early this year, "federal appropriations for the alcohol and drug projects and formula grant programs totalled $332 million." But, as NASADAD has reported more recently:

"In the first half of FY 1983, the alcohol and drug portion of the ADM Block Grant equalled only $222.8 million -- a 33 per cent reduction from fiscal 1980 levels without adjusting for inflation. If the

REPLY TO:
[ ] National Headquarters - 624 South Michigan Avenue, Chicago, Illinois 60605 - Phone (312) 663-1130
[ ] Office of the President - 118-21 Queens Blvd., Suite 212, Forest Hills, New York 11375 - Phone (212) 520-5285
[ ] Office of the Secretary - 39 East School House Lane, Philadelphia, Pennsylvania 19144 - Phone (215) 763-2880

inflation rates of 10 per cent in 1981 and 6.1 per cent in 1982 are taken into account, current federal funding levels of alcohol and drug treatment and prevention services represent a 42 per cent reduction in real dollars."

Drug programs have learned to brace for this kind of damage. In FY 1979, total federal funding for our programs in New York State was $31 million. Two years later, it was $27.6 million.

The next year, fiscal 1982, it was slashed even more drastically to $19.1 million, representing a total cut of $12 million in only three years -- as inflation rates rose and our waiting lists grew longer.

Because vulnerable young people are involved, the effects have been seriously damaging and, in some cases, disastrous. Although the federal strategy speaks specifically of curbing drug abuse among school-age youngsters, cuts in the ADM Block Grant stripped school-based prevention programs of more than $5 million this past year. If state officials and the Legislature had not stepped in with emergency help, thousands of kids would have been left to the pushers.

A "federal" strategy that leaves all the responsibility for sustaining education, prevention and treatment programs to states and localities is simply a contradiction in terms -- and an abdication of official responsibility.

These programs should be given the same recognition and support by Washington that is devoted to the drug interdiction effort. We fully support the concept of state autonomy in planning and implementation of service programs. We do not believe that they can be made autonomous of federal funding. The crisis is national and the strategy for meeting it must also be truly national. SPARK and programs like it throughout the U.S. are doing all they can to defend the young against drugs. To cut their supply lines and withhold the reinforcements they need is a strategy for defeat.

TESTIMONY
PRESENTED TO
HOUSE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

BY

NICHOLAS L. PICCONE, ED.D., EXECUTIVE DIRECTOR
COORDINATING OFFICE FOR DRUG AND ALCOHOL ABUSE PROGRAMS
PHILADELPHIA DEPARTMENT OF PUBLIC HEALTH

NOVEMBER, 1983

I AM NICHOLAS L. PICCONE, EXECUTIVE DIRECTOR OF THE PHILADELPHIA COORDINATING OFFICE FOR DRUG AND ALCOHOL ABUSE PROGRAMS WHICH IS A COMPONENT OF THE PHILADELPHIA DEPARTMENT OF PUBLIC HEALTH.

THE COORDINATING OFFICE FOR DRUG AND ALCOHOL ABUSE PROGRAMS (KNOWN AS CODAAP) WAS CREATED IN 1973 TO DEVELOP AND ADMINISTER A DRUG AND ALCOHOL PREVENTION AND TREATMENT SYSTEM IN PHILADELPHIA COUNTY.

DURING THE SUCCEEDING 10 YEARS, COODAP HAS ACHIEVED CONSIDERABLE SUCCESS IN ASSURING THAT:

- THE ARRAY OF PHILADELPHIA'S DRUG AND ALCOHOL SERVICES IS APPROPRIATE AND ADEQUATE TO THE NEEDS OF PHILADELPHIA CLIENTS;
- THE SYSTEM AS A WHOLE IS RESPONSIVE TO CHANGING TRENDS;
- THE RELATIONSHIPS BETWEEN SERVICE PROVIDERS OPERATE IN A WAY WHICH GUARANTEES CLIENTS NOT ONLY A CONTINUUM OF CARE BUT ALSO SMOOTH TRANSITIONS WITHIN THE NETWORK;
- THE CARE DELIVERED CONFORMS TO ESTABLISHED STANDARDS;
- THE PERSONNEL INVOLVED ARE QUALIFIED TO CARRY OUT THEIR RESPONSIBILITIES;
- THE FUNDS SUPPORTING THE SYSTEM ARE ADEQUATE;
- THE SERVICES PURCHASED ARE THE BEST AVAILABLE FOR THE LEAST MONEY, AND THAT THE SERVICES PAID FOR ARE THE SERVICES RECEIVED;
- EACH PROVIDER AGENCY ADHERES TO SOUND MANAGEMENT PRINCIPLES.

THE PHILADELPHIA D & A SYSTEM CURRENTLY INCLUDES APPROXIMATELY 7,000 CLIENTS IN TREATMENT. IT IS A COMPREHENSIVE SYSTEM OF OUTPATIENT, RESIDENTIAL, PARTIAL HOSPITALIZATION AND EMERGENCY SERVICES DELIVERED BY 70 FACILITIES STRATEGICALLY LOCATED THROUGHOUT THE CITY. IT IS A NETWORK OF SERVICES EXEMPLIFIED BY COOPERATION AND COORDINATION AMONG AGENCIES. IT IS A CLIENT-CENTERED SYSTEM. PROGRAM DIRECTORS KNOW ONE ANOTHER, TALK TO ONE ANOTHER AND WORK TOGETHER FOR THE BENEFIT OF EVERY CLIENT IN THE SYSTEM. IT IS RARELY A PROBLEM IN PHILADELPHIA TO MEET THE SPECIAL NEEDS OF A PARTICULAR CLIENT.

THERE WERE NO PREVENTION/EARLY INTERVENTION PROGRAMS IN PHILADELPHIA PRIOR TO 1973. ONE OF CODAAP'S TOP PRIORITIES IN 1973 WAS THE DEVELOPMENT OF A PREVENTION/EARLY INTERVENTION PROGRAM DIRECTED TOWARD HIGH RISK YOUTH. WITHIN A YEAR, PHILADELPHIA HAD PROGRAMS IN 22 HIGH SCHOOLS AND 10 JUNIOR HIGH SCHOOLS. WITHIN THE PAST 10 YEARS, PREVENTION/EARLY INTERVENTION SERVICES HAVE EXPANDED TO 35 HIGH SCHOOLS, 20 JUNIOR HIGH AND MIDDLE SCHOOLS AND 13 ELEMENTARY SCHOOLS. ADDITIONALLY, CODAAP HAS EXTENDED PREVENTION PROGRAMMING TO INCLUDE ON-SITE SERVICES AT PUBLIC HOUSING PROJECTS, RECREATION FACILITIES, AND SENIOR CITIZEN CENTERS.

DURING THE PAST YEAR, THE NEW FEDERALISM STRATEGY HAS CUT DEEPLY INTO OUR ABILITY, NOT ONLY TO PROVIDE HIGH QUALITY SERVICES TO ALL THOSE IN NEED, BUT TO CONTINUE THE FOCUS ON THOSE MANAGEMENT PRINCIPLES DESCRIBED EARLIER IN THIS PRESENTATION. IT HAS BEEN A YEAR OF RESPONDING TO FISCAL CRISES. IT HAS RESULTED IN

THE SEVERE CURTAILMENT OF PREVENTION PROGRAMS (INCLUDING SUMMER ALTERNATIVE PROGRAMS FOR YOUTH AT RISK) AS WELL AS ELIMINATION OF ALL ANCILLARY SERVICES SUCH AS VOCATIONAL AND EDUCATIONAL TRAINING. IT HAS ALSO CULMINATED IN THE CLOSING OF PROGRAMS AND CONTRIBUTED TO LARGE SCALE OVER-UTILIZATION OF REMAINING PROGRAMS. OF COURSE, THIS HAS A NEGATIVE IMPACT ON CLIENT CARE.

IN FISCAL YEAR 1981, THE CITY OF PHILADELPHIA RECEIVED A TOTAL OF OVER $7 MILLION ($7,272,760) FROM THE FEDERAL GOVERNMENT. IN FISCAL YEAR 1985, WE ARE SLATED TO RECEIVE $4.5 MILLION ($4,511,960). CONSIDERING INFLATION AND COST OF LIVING INCREASES OF THE FOUR YEAR PERIOD, THE IMPACT OF THIS LOSS TO OUR SYSTEM IS, IN A WORD, DEVASTATING.

THE CITY/COUNTY OF PHILADELPHIA, WITH A 1980 POPULATION OF 1,688,210 IS THE LARGEST CITY IN PENNSYLVANIA AND THE FOURTH LARGEST IN THE UNITED STATES. PHILADELPHIA, AS A MAJOR METROPOLITAN AREA, IS BESET WITH A MYRIAD OF PROBLEMS NOT ALWAYS IDENTIFIED BY OTHER LESS POPULATED AREAS. A VARIETY OF SOCIAL AND DEMOGRAPHIC INDICATORS SUCH AS UNEMPLOYMENT, DEATHS, CRIME RATES AS WELL AS TREATMENT SERVICES INDICATORS DEPICT THE DRUG ABUSE PROBLEM IN PHILADELPHIA.

UNEMPLOYMENT IS EXTREMELY HIGH AMONG CLIENTS IN PHILADELPHIA SUBSTANCE ABUSE TREATMENT PROGRAMS. APPROXIMATELY 75% OF THE CLIENTS IN THE PHILADELPHIA TREATMENT SYSTEM ARE CURRENTLY UNEMPLOYED.

ACCORDING TO RECENT DAWN DATA, HEROIN RELATED DEATHS AND ALL DRUG RELATED DEATHS IN PHILADELPHIA HAVE INCREASED. NARCOTIC ARRESTS AND OFFENSES HAVE INCREASED CONTINUING A TREND WHICH STARTED IN THE FIRST SIX MONTHS OF 1980. INTAKES FOR USERS OF HEROIN AND BARBITURATES HAVE INCREASED. COCAINE USE HAS INCREASED BY 30% SINCE 1981.

IN FISCAL YEAR 1982 (MOST RECENT AVAILABLE TREATMENT DATA), THERE WERE APPROXIMATELY 19,000 ADMISSIONS INTO CODAAP FUNDED PHILADELPHIA SUBSTANCE ABUSE PROGRAMS. OF THESE ADMISSIONS, 47% WERE ADMITTED FOR DRUG ABUSE PROBLEMS. DURING THIS YEAR, 5,000 CLIENTS WERE ADMITTED FOR HEROIN AND OTHER OPIATE ABUSE. AT ANY GIVEN TIME DURING THE PAST SEVERAL YEARS THERE HAVE BEEN AT LEAST 2,300 CLIENTS RECEIVING SERVICES AT 11 METHADONE MAINTENANCE PROGRAMS. THIS CURRENTLY REPRESENTS 130% UTILIZATION OF 1,834 FUNDED SLOTS.

AMONG DRUG ABUSE ADMISSIONS IN PHILADELPHIA, THE SECOND HIGHEST CATEGORY OF PRIMARY DRUG OF ABUSE (AFTER HEROIN AND OTHER OPIATES) IS AMPHETAMINES OF WHICH THERE WERE 1,500 IN FY'82.

DATA FROM THE DRUG ABUSE WARNING NETWORK (DAWN) FOR CALENDAR YEAR 1982 (THE MOST RECENT DATA AVAILABLE) PLACES PHILADELPHIA FOURTH HIGHEST IN THE COUNTRY EXCEEDED ONLY BY NEW YORK, LOS ANGELES AND DETROIT IN EMERGENCY ROOM AND MEDICAL EXAMINER EPISODES INVOLVING DRUG ABUSE. THE MOST FREQUENT DRUG EPISODES IN HOSPITAL EMERGENCY ROOMS IN THE PHILADELPHIA METROPOLITAN AREA WERE ALCOHOL-IN-COMBINATION WITH DRUGS, VALIUM (DIAZEPAM), HEROIN/MORPHINE, AND AMPHETAMINES, IN THAT ORDER. OF SPECIAL SIGNIFICANCE IS THE

FACT THAT IN 1982, THERE WERE 57% MORE HEROIN/MORPHINE EMERGENCY ROOM MENTIONS THAN IN 1981.

THE EXTENT OF THE DRUG PROBLEM IN PHILADELPHIA CAN FURTHER BE SEEN VIA THE CURRENT UTILIZATION RATES OF PHILADELPHIA TREATMENT PROGRAMS. OF THE 42 CODAAP CONTRACT FACILITIES PROVIDING DRUG ABUSE TREATMENT SERVICES, 62% ARE ABOVE CONTRACT CAPACITY (GREATER THAN 100% UTILIZATION) AND 81% ARE ABOVE 90% UTILIZATION.

WHEN WE LOOK AT AN OVER-UTILIZED SYSTEM, WE BECOME CONCERNED ABOUT QUALITY OF CARE ISSUES. WE DEVELOP ALLOCATIONS AND CONTRACTS WITH DRUG AND ALCOHOL AGENCIES IN PHILADELPHIA, ESTABLISHING STANDARDS FOR BOTH QUANTITATIVE SERVICE OBJECTIVES AND QUALITY OF CARE. WHEN DEMANDS FOR SERVICE INCREASE BEYOND AN AGENCY'S REASONABLE CAPABILITIES, OUR EXPECTATIONS HAVE TO BE LOWER. WITH INCREASING OVERLOAD STRESS ON STAFF INCREASES, STAFF MORALE IS LOWERED AND STAFF BURNOUT OCCURS MORE FREQUENTLY.

REGARDING THE ISSUE OF RESEARCH, IN THE PAST THERE WERE RESEARCH ACTIVITIES WHICH ALLOWED US TO MAINTAIN A STATE OF THE ART SERVICE SYSTEM. GIVEN CURRENT FISCAL RESTRAINTS, HOWEVER, WE HAVE BEEN FORCED TO CONSIDER RESEARCH A LUXURY WE CAN NO LONGER AFFORD. WE WOULD LIKE TO RETURN TO THAT RANGE OF ACTIVITIES, BUT WE HAVE NOT RECENTLY HAD THE RESOURCES WHICH ALLOW FOR SUCH INVOLVEMENT.

REGARDING THE ISSUE OF LAW ENFORCEMENT, THIS AREA IS NOT WITHIN CODAAP'S PURVIEW, SO WE ARE UNABLE TO RESPOND TO THIS SEGMENT OF THE FEDERAL STRATEGY.

I WOULD LIKE TO SPECIFICALLY COMMENT ON THE IMPACT THAT PRESENT BLOCK GRANT FUNDING LEVELS AND MECHANISMS HAVE HAD ON PHILADELPHIA'S DRUG AND ALCOHOL SERVICES SYSTEM.

AS I HAVE INDICATED EARLIER, WE HAVE WORKED TO MAINTAIN A COMPREHENSIVE ARRAY OF DRUG AND ALCOHOL ABUSE SERVICES THROUGH A PERIOD OF INCREASING FISCAL STRESS AND EROSION OF FUNDING. PHILADELPHIA AGENCIES FUNDED THROUGH CODAAP HAVE RECEIVED NO SIGNIFICANT FUNDING INCREASES SINCE FY'79. CODAAP HAS DEVELOPED AND IMPLEMENTED FUNDING CRITERIA DESIGNED TO MAXIMIZE PRODUCTIVITY WHILE MAINTAINING QUALITY OF SERVICE DELIVERED. WE HAVE INTENSIFIED OUR PROGRAM MONITORING TO INCREASE ACCOUNTABILITY FROM OUR SYSTEM. HOWEVER, WE HAVE REACHED A PRACTICAL LIMIT IN THESE EFFORTS, AND THE ADDITIONAL 25% LOSS OF FEDERAL BLOCK TREATMENT FUNDS NOW SCHEDULED FOR FY'85 WILL CAUSE CATASTROPHIC REDUCTIONS IN SERVICE.

THE NEW FEDERALISM, AS DESIGNED AND IMPLEMENTED BY THE PRESENT ADMINISTRATION IN WASHINGTON, GIVES THE STATE FULL RESPONSIBILITY FOR THE ALLOCATION OF FEDERAL BLOCK GRANT FUNDS. THIS MOVEMENT AWAY FROM DIRECT FEDERAL FUNDING IS WREAKING FISCAL HAVOC ON PHILADELPHIA'S DRUG AND ALCOHOL ABUSE SERVICE SYSTEM.

LET US FOCUS ON THE ACTUAL LOSS TO THE CITY OF PHILADELPHIA'S D & A ABUSE SERVICE DELIVERY SYSTEM DUE TO THE EROSION OF FEDERAL AND STATE SUPPORT. A REVIEW OF THE BLOCK GRANT CUTBACK SCHEDULE BOTH AS PLANNED AND AS ACTUALLY IMPLEMENTED BY THE STATE OFFICE OF DRUG AND ALCOHOL PROGRAMS REVEALS HOW DIFFICULT IT HAS BEEN

(AND IS) FOR CODAAP TO PROVIDE RATIONAL, PROACTIVE PLANNING FOR THE SYSTEM.

THE CUTBACKS, AS PLANNED, WERE: FY'83 - 15% OR APPROXIMATELY $930,000; FY'84 - NO ADDITIONAL CUT; AND, FY'85 - 10% ADDITIONAL CUT OF APPROXIMATELY $595,000. HOWEVER, AS IMPLEMENTED WE RECEIVED THE 15% FY'83 CUT; IN FY'84 WE RECEIVED A 4.5% TREATMENT AND A 4.1 PREVENTION CUT TOTALLING APPROXIMATELY $280,000. THE PRESENT STATE PROJECTED CUTBACK FOR FY'85 IS MORE THAN DOUBLE THE PLANNED 10%, I.E., A 25% CUTBACK OR APPROXIMATELY $1,469,300 MILLION IN TREATMENT FUNDING. THE FY'85 CUT ADDED TO PREVIOUS CUTS AMOUNTS TO AN OVERALL CUT IN REAL DOLLARS OF 40% ($2,760,800). WHEN OTHER REVENUE THAT IS GENERATED BY THE PROVISION OF THESE SERVICES IS ADDED TO THE FEDERAL CUTBACK SCHEDULE, THE TRUE DOLLAR LOSS APPROACHES $2 MILLION IN FY'85 ALONE, AND APPROXIMATELY $4 MILLION OVER THE ENTIRE THREE YEAR FEDERAL BLOCK PERIOD.

THE CITY OF PHILADELPHIA HAS TRADITIONALLY RECOGNIZED THE IMPORTANCE OF OUR DRUG AND ALCOHOL SYSTEM AND HAS BEEN GENEROUS WITH MATCHING FUNDS. IT HAS, IN FACT, CONSISTENTLY EXCEEDED STATE BASE MATCHING REQUIREMENTS BY PROVIDING 25% OF OUR FUNDING AS OPPOSED TO ONLY 10%. AS A RESULT OF FEDERAL REDUCTIONS TO ALL DEPARTMENTS TOTALING $53 MILLION, THE CITY IS NO LONGER ABLE TO CONTINUE THIS LEVEL OF FUNDING AND HAS HAD TO DIVERT ½ MILLION DOLLARS OF THE OVERMATCH TO OTHER AREAS OF CITY GOVERNMENT. THIS SIGNIFICANT REDUCTION WHICH IS INDIRECTLY THE RESULT OF THE BLOCK GRANT PROCESS HAS FURTHER IMPACTED ON OUR ABILITY TO MAINTAIN A COMPREHENSIVE SERVICE DELIVERY SYSTEM.

AN EXAMPLE OF THIS REVENUE LOSS IN FY'85 IN HUMAN TERMS WOULD MEAN THE ELIMINATION OF TWO MAJOR COMPREHENSIVE ALCOHOL AND DRUG ABUSE TREATMENT PROGRAMS IN THEIR ENTIRETY. THIS CUTBACK REPRESENTS THE ELIMINATION OF ABOUT 79,000 SERVICE UNITS DELIVERED THROUGH OUTPATIENT, RESIDENTIAL, DETOX, METHADONE MAINTENANCE, EMERGENCY CARE AND POLYDRUG TREATMENT FOR ABOUT 6,000 CLIENT ADMISSIONS. AT THE AGENCY STAFF LEVEL, THIS ALSO REPRESENTS A LOSS OF ABOUT 160 STAFF POSITIONS. THIS LOSS WOULD BE ADDED TO THE NINE DRUG AND ALCOHOL AGENCIES OR SERVICE COMPONENTS THAT HAVE BEEN EITHER DEFUNDED OR CLOSED AS A RESULT OF THE SYSTEM'S DWINDLING FISCAL RESOURCES SINCE FY'82. PHILADELPHIA IS EXPERIENCING THIS REDUCTION OF SERVICES AT THE SAME TIME THAT ECONOMIC FACTORS IN OUR SOCIETY DEMAND EVEN MORE SERVICES FOR A SEVERELY STRESSED URBAN POPULATION.

LET ME NOW COMMENT ON THE WAY WHICH THE STATE OF PENNSYLVANIA HAS MANAGED BLOCK GRANT FUNDING TO THE DETRIMENT OF THE CITY OF PHILADELPHIA.

THE SEVERE FISCAL REDUCTIONS NOTED ABOVE ARE THE RESULT OF THE NEW FORMULA, OR METHOD OF ALLOCATIONS, BEING IMPLEMENTED BY ODAP (THE STATE DEPARTMENT OF HEALTH'S OFFICE OF DRUG AND ALCOHOL PROGRAMS). THIS NEW FORMULA IS BASED ON A STATEWIDE DISTRIBUTION OF FUNDS WHICH WILL REALIZE PER CAPITA AND EQUITY INCREASES TO ALL COUNTIES BUT PHILADELPHIA. THE BASIC RATIONAL SEEMS TO BE POLITICAL EXPEDIENCY RATHER THAN THE ACTUAL DRUG AND ALCOHOL SERVICE NEEDS OF ANY GIVEN COUNTY. IF WE REVIEW THE UNIFORM DATA COLLECTION SYSTEM (UDCS) REPORTS FROM JANUARY TO APRIL OF

1983, WE GET A CLEAR PICTURE OF OUR CITY'S D & A SERVICE NEEDS. IN THESE REPORTS, 75% OF OUR PROGRAMS ARE CHRONICALLY OVER-UTILIZED, SOME BY AS MUCH AS 200%. THE REMAINING 25% ARE UTILIZED BETWEEN 85 AND 100%. THESE STATISTICS EMPHASIZE THE OVERWHELMING NEED FOR D & A SERVICES IN PHILADELPHIA. THIS NEED IS NOT BEING CONSIDERED AS AN IMPORTANT FUNDING VARIABLE BY ODAP.

THE FEDERAL BLOCK GRANT LEGISLATION REQUIRES THAT AT LEAST 20% OF A STATE'S D & A BLOCK GRANT ALLOCATION BE ASSIGNED TO FUNDING PREVENTION SERVICES. UNFORTUNATELY, SINCE NO ADDITIONAL FUNDS WERE APPROPRIATED FOR PREVENTION SERVICES, THIS 20% HAS BEEN TAKEN AWAY FROM EXISTING ALREADY OVER-UTILIZED TREATMENT SERVICES IN PHILADELPHIA. IN PENNSYLVANIA, THE STATE STRATEGY FURTHER PENALIZES PHILADELPHIA. AFTER TAKING THE PREVENTION SET-ASIDE FUNDS FROM PHILADELPHIA TREATMENT SERVICE FUNDING, THE STATE OFFICE DID NOT CHOOSE TO TAKE THE LOGICAL ACTION OF APPLYING THE FEDERAL BLOCK PREVENTION FUNDS TO PHILADELPHIA WHERE DOCUMENTED NEED HAS LONG BEEN ESTABLISHED. AS I NOTED ABOVE, THEY CHOSE TO DISTRIBUTE THESE PREVENTION BLOCK FUNDS THROUGHOUT THE STATE EXCLUDING PHILADELPHIA, USING SO-CALLED PER CAPITA AND "EQUITY" FORMULAS. BECAUSE THIS MONEY WAS NOT ALLOCATED ON A NEED BASIS, ODAP IS IN THE POSITION OF HAVING A $1.5 MILLION SURPLUS OF PREVENTION BLOCK FUNDS IN FY'85 FOR WHICH THEY HAVE NO PLANS. AT THE SAME TIME, ACROSS THE STATE THERE WILL BE A $2.8 MILLION SHORTFALL IN TREATMENT BLOCK FUNDS. WE WOULD LIKE TO STRONGLY RECOMMEND THAT STATES BE REQUIRED TO ALLOCATE FEDERAL BLOCK GRANT FUNDS ON THE BASIS OF NEED WITH MONITORING BY THE INSTITUTES TO TO INSURE THAT THIS REQUIREMENT IS, IN FACT, BEING MET.

AS A RESULT OF THE STATE'S ACTIONS, PHILADELPHIA TREATMENT PROGRAMS IN FY'85 WILL HAVE LOST 40% OF THE FEDERAL FUNDING THEY WERE RECEIVING BEFORE BLOCK GRANTS WERE IMPLEMENTED AND, IN SPITE OF THE CONGRESSIONAL MANDATE EMPHASIZING INCREASED FUNDING FOR PREVENTION, IN FY'85 THERE WILL BE FEWER FEDERAL DOLLARS FOR PREVENTION IN PHILADELPHIA THAN THERE WERE IN FY'81.

WE ENDORSE THE POSITION THAT MORE FUNDS SHOULD BE MADE AVAILABLE FOR EXPANSION OF PREVENTION SERVICES, BUT SUCH FUNDS FOR PREVENTION SHOULD NOT BE TAKEN FROM EXISTING, OVER-UTILIZED TREATMENT SERVICES.

I WOULD LIKE TO PRESENT OUR SPECIFIC RECOMMENDATIONS:

- FIRST AND FOREMOST, WE RECOMMEND THAT THE FEDERAL GOVERNMENT PROVIDE DIRECT FUNDING TO SEVERAL OF THE LARGEST CITIES IN THE UNITED STATES WITH POPULATIONS EXCEEDING 1,000,000, ON A PILOT BASIS. AS YOU KNOW, THE POPULATIONS OF THESE CITIES EXCEED THOSE OF SEVERAL STATES. THEY HAVE COMPLEX GOVERNMENTS WITH CHECKS AND BALANCES TO DEAL WITH ENORMOUSLY COMPLEX PROBLEMS. TO IMPOSE AN ADDITIONAL BUREAUCRATIC STRUCTURE ON THESE CITIES FOR THE DISBURSEMENT OF PUBLIC FUNDS IS NOT ONLY ENORMOUSLY COSTLY BUT GROSSLY INEFFICIENT TO SERVICE DELIVERY. IN THE DELIVERY OF DRUG AND ALCOHOL SERVICES, WE HAVE, HOWEVER, BEEN CRIPPLED BY THE NEW FEDERALISM, AND DIRECT FUNDING, IN OUR OPINION, WOULD MOST EFFECTIVELY REDRESS THE ONGOING ABUSE OF OUR SYSTEM.

- SECONDLY, WE RECOMMEND THAT THE FEDERAL GOVERNMENT INCREASE FUNDING TO MEET THE LEVEL OF NEED. WHILE THE PROBLEM OF DRUG AND ALCOHOL ABUSE HAS BEEN INCREASING IN RECENT YEARS, RESOURCES TO RESPOND TO THE PROBLEM HAVE DRASTICALLY DECREASED. THE GOVERNMENT HAS CONSISTENTLY IGNORED THE PUBLIC DEMAND THAT DRUG AND ALCOHOL ABUSE IN THIS COUNTRY RECEIVE PRIORITY BY OUR ELECTED OFFICIALS AT ALL LEVELS.
- THIRDLY, WE ARE RECOMMENDING A REVIEW OF THE PROCESS FOR FUNDING PREVENTION PROGRAMMING AS DEFINED BY THE FEDERAL BLOCK GRANT LEGISLATION. WE WOULD ASK YOU TO REVIEW AND RECONSIDER THE INFLEXIBILITY OF THE CURRENT 20% REQUIREMENT AFTER A THOROUGH EVALUATION OF ITS IMPLEMENTATION BY THE VARIOUS STATES. PROVISIONS FOR EXCEPTIONS SHOULD BE DEVELOPED. WE STRONGLY RECOMMEND INCREASES IN FUNDING FOR PREVENTION SERVICES. SUCH INCREASES SHOULD BE SUPPORTED WITH NEW FUNDS. THEY SHOULD NOT BE MADE AT THE EXPENSE OF EXISTING NEEDED TREATMENT SERVICES. MORE FLEXIBILITY NEEDS TO BE BUILT IN SO THAT NO CLIENT IS DENIED NEEDED TREATMENT SERVICES WHILE FUNDS ARE BEING DIVERTED FOR PREVENTION SERVICES IN AREAS WHERE NO DEFINED NEED EXISTS. PREVENTION FUNDS SHOULD HAVE TO BE USED WHERE NEEDED. CERTAINLY SURPLUSES EXCEEDING $1 MILLION IN A STATE SHOULD NOT BE ALLOWED TO OCCUR.

HOPEFULLY, ENHANCED PREVENTION PROGRAMS COULD REDUCE THE NEED FOR TREATMENT PROGRAMS AT SOME TIME IN THE FUTURE. HOWEVER, AT THIS TIME, DRUG AND ALCOHOL ABUSE CANNOT BE PREVENTED IN THE SAME WAY AS SMALL POX, SO APPROACHES TO PREVENTION NEED TO BE MUCH MORE CAREFULLY THOUGHT OUT.

- LASTLY, IN THE EVENT THAT THE LARGEST CITIES IN THE COUNTRY ARE NOT FUNDED DIRECTLY, WE RECOMMEND THAT THE FEDERAL GOVERNMENT MANDATE THAT BLOCK GRANT FUNDS BE DISTRIBUTED SOLELY ON THE BASIS OF NEED. TO ALLOW THIS POLITICAL FOOTBALL GAME TO CONTINUE WHILE PEOPLE ARE IN SEVERE NEED OF SERVICES IS UNCONSCIONABLE. ALTHOUGH WE AGREE THAT NO AREA OF THE COUNTRY IS IMMUNE TO THE PROBLEM OF DRUG AND ALCOHOL ABUSE, NIDA'S DATA BASE REFLECTS THAT URBAN AREAS HAVE GREATER NEEDS THAN RURAL AREAS.

IN CLOSING, I WOULD LIKE TO THANK YOU FOR THIS OPPORTUNITY TO SHARE WITH YOU OUR EXPERIENCE IN PHILADELPHIA OF THE NEW FEDERALISM AS APPLIED TO DRUG AND ALCOHOL BLOCK GRANT FUNDING.

JOYCE D. NALEPKA
Senior Vice President

NATIONAL FEDERATION OF PARENTS FOR DRUG-FREE YOUTH

Testimony before the Select Committee
on Narcotic Abuse and Control

November 2, 1983

Adolescent Drug Use -

"The difference will be made by parents, educators, businessmen, service organizations, and the media working to take away the customers, while government continues to stem the supply." 11-2-83

Mr. Chairman, Members of the Committee,

My name is Joyce Nalepka, I am Senior Vice President of the National Federation of Parents for Drug-Free Youth. The Federatic appreciates the opportunity to present to you today and report that there is reason for optimism in the fight against adolescent drug and alcohol use. The optimism is coupled with a determinatic that we, as parents, have made that we must make a difference--no matter what it takes, because our childrens' lives are on the line

After years of frustration while we watched children in our communities become helplessley and hopelessly drug involved and parents, educators, physicians and others either didn't know what was happening at all or didn't know how to approach the problem, we are beginning to see some light at the end of the tunnel. The hope began when parents spontaneously and simultaneously in many parts of the country began to take a stand and do what Americans do best--help each other. Parents began gathering in livingrooms, schools, churches and other local meeting places to work out plans for curbing the epidemic. As we look back at the history of the national parent movement, we find that activity began in late 1977.

Most of us worked alone in the beginning, with no funding and no work place--except our kitchens. My personal initiation came in December, 1977 when a former babysitter asked me to drive him to a rock concert because he wasn't old enough to drive and his father had the flu. I have a special understanding for parents who don't know about the drug scene, because I knew so little then that I not only drove him but took my 5 and 9 year old sons along! I believed people went to rock concerts to listen to music. I watched in horror as 70 to 80 percent of the audience of mostly teenagers lit up, snorted and guzzled. I would guess the average age of the audience to have been 14 or 15! My immediate reaction was - not my kids. My activism began that night as I met with the management and demanded our money refunded. I left the concert with a much-broadened perspective of what parents needed to be aware of to get children through their teen years drug-free. I was also keenly aware that most parents knew as little as I did and unless other parents got involved - my kids wouldn't have a chance. I began to share what I had learned and, without exception, found other parents to be as outraged as I was. I found the same feelings among parents on a recent USIA visit to Peru and Jamaica.

By early 1978, we began hearing of other parents in many parts of the country that were becoming aware and active also. The best plan we have come up with is the education and involvement of parents, educators, physicians and other concerned citizens into parent/community task forces to address the problem at the local level, then network the state and, finally, provide a national umbrella to hold the groups together and provide the unified strength that can change the epidemic of panic into a glimmer of hope.

The point must be made that no one group can solve this problem. I'm pleased that Father John McVernon is sharing this panel. NADAD has prevention experience and dedication and we're pleased that they are willing to share that with our organization. It was Father John who pointed out the need for business expertise in the NFP. We took his suggestion and NADAD's founder, Rex Tompkins, now serves as a valued member of our board of directors.

He was joined by Jack O'Brien, McNeil Pharmaceutical President and Tom Marquez of Texas.

The National Federation of Parents for Drug-Free Youth was formed officially in May, 1980 and serves as the national parent group umbrella. The Federation provides technical assistance, materials, advice and encouragement to nearly 4,000 existing and hundreds of newly developing parent groups throughout the country. NFP has developed and makes available materials specifically aimed at assisting local parent group organizations in getting started, developing ongoing training programs, and initiating community action projects as well as providing legislative representation on Capitol Hill and a national speaker's bureau. The Federation is funded by Foundations, Corporations, and individuals from the private sector only.

We have learned that drug and alcohol use by adolescents has created a new "state of the art" for education, parenting, treatment and counselling.

These young drug users have rewritten all the rules and former beliefs that "only the already troubled" become involved. Most parents we talk with feel their child was a normal, healthy teen until they became drug involved. However, many parents tell us that counsellors spend months trying to find the root of the problem and finally conclude that "the child has a drug problem" and when the drug is removed, most of these children return to normal-or nearly so-unless drugs have already done permanent damage. More informed counsellors now look for drugs first when treating troubled teens and pre-teens!

We have found several apparent reasons for drug and alcohol involvement by children.

> Almost universally, parents were uninformed.
>
> School personnel were reluctant to become involved and did not share openly information about drug involvement with parents.
>
> Rock music glamorized--even promoted drug and alcohol use.
>
> Local alcohol merchants didn't check I.D.'s and one in Montgomery County, Md. provided a free bottle of wine if the kids told him it was their birthday. (He is no longer in business.)
>
> Schools provided smoking areas that have become havens for drug use and dealing--according to undercover agents and young people in treatment.
>
> Movies and television have glamorized drug and alcohol use.
>
> A supply is abundantly available. Marijuana must be taken seriously--or we'll never solve the heroin problem.
>
> And the ever-present excuse---peer pressure!

We also found that parents, generally, were saying "NO" to drug and alcohol use by their children but the community wasn't backing up that message. Parent/community groups provide the strength and unity that pulls the community together around the family for the protection of all children. Our goal is to get enough information to every parent in this country to enable them to prevent drug use among 7-17 year olds.

A major problem has been inattention to the epidemic by the media--unless it was a spectacular headline that promoted legalization or a suit by NORML to stop paraquat spraying or keep drug paraphernalia shops open, or attempts to relax marijuana laws - an effort stopped in its tracks by the parent movement.

The media seemed to have a great flair for presenting more controversy than information, particularly regarding marijuana. We don't mean to target the press. We respect the rights and need for a free press. We oppose censorship but feel some segments of the media have practiced a form of censorship not discussed much. I am referring to censorship by omission which has been most obvious when it comes to reporting the health hazards of marijuana, which have been clear since 1972, the spraying of paraquat (which the NFP supports) or, the rescheduling of marijuana under the disquise of marijuana for medicine (which the NFP opposes and would encourage our Congressmen not to support). Actually, several have removed their names from the bill since receiving accurate information. Again, we support a free press, we only ask that it be objective as well. There is also much good news about the media! NBC, some time ago, issued a ruling that drug jokes be removed from their networks, Reader's Digest has done a cover story on the parent movement that caused over 1,000 people to join the movement in two weeks and, almost daily, we get a call from an important publication that wants to do a story and list the Federation as a resource. Demand for our services are far ahead of our ability to fund them! Funds are being sought from the private sector.

The National Federation has educated thousands of parents and other community members and is helping bring these concerned citizens together in parent/community task forces at the local level in an unprecedented effort by television and the local community at 10,675 town meetings TONIGHT, November 2, at 8:00 p.m. in every state in America! Never before on any issue have so many people come together!

NFP is a national co-sponsor with Public Broadcasting Service of the "Chemical People" project which will be carried on all 300 PBS stations! Tonight's program will present the, problem as it exists, explain the medical and scientific reasons why children should not use drugs, including alcohol, and next week's program, again to be viewed at town meetings in the community, will give guidelines for organizing at the local level. There are special programs for Spanish families and the hearing impaired. Eight governors in the northeast are heading up their state efforts, Congressional wives who have formed Congressional Families for Drug-Free Youth, are assisting in many states. Lana Bethune, wife of Congressman Ed Bethune, is honorary state chairman in Arkansas. Houston, Texas has 100 billboards advertising the programs and 875 town meetings scheduled. D.C. reported 80 meetings scheduled tonight. A Baptist church in Missouri will bus its entire congregation to a town meeting. Ten town meetings are being held on Indian reservations. Sacramento, California sent every home a notice in their water bill. The list goes on and on. There are over 50,000 volunteers coordinating the project that now has the support of over 30 national organizations.

All these statistics, and more, were reported by WQED Pittsburgh's President, Lloyd Kaiser, at the White House on October 24 as the Presidents of 32 national organizations representing millions of Americans and Chief Executive Officers of several businesses listened. Michael Landon of Little House on the Prairie and the nation's First Lady were hosts.

The Washington Post wrote a lengthy article on Michael Landon's hair--and never mentioned this landmark event! I mention it because this was an important event--not just to us--

but to the nation--and because the Washington Post is such an important paper. It is quoted worldwide and could have made a dramatic impact on our neighbors around the world who are beginning to search for answers to adolescent drug involvement in their own countries. In fact, our organization has met with delegations from 12 foreign countries in the last two years. First Ladies of other nations are conferring with Nancy Reagan.

The national involvement of the media is imperative if we're going to save this nation's most precious resource--its children. We hope commercial radio and television will follow the lead of PBS and give this issue the attention we feel it must have.

The National Federation's theme for 1983-84 is "COME ON, AMERICA! STICK YOUR NECK OUT FOR KIDS AND HELP STOP ADOLESCENT DRUG AND ALCOHOL USE." The NFP's first award for "sticking your neck out for kids" went to Nancy Reagan in October. We gave her a 7 foot tall stuffed giraffe at our second annual conference. (McDonald's Corporation provided 600 smaller giraffes for every parent in attendance for sticking their necks out in their home town.)

The American Medical Association has funded the production of one (1) million flyers using our "Stick your neck out theme" to provide back up to the Chemical People town meetings and introduce our new, national 800 number which begins operation today to respond to the requests generated by Chemical People and the increased awareness brought to the problem by Nancy Reagan. The new number is,appropriately, 800-554-KIDS! We invite you to publicize it so parents who are still hurting and searching for help for their children or who want to learn how to prevent the problem won't have to reinvent the wheel. We are ready to help. Three Congressional wives have already signed up to answer calls.

We hope everyone in our country will truly lay differences aside and pull together on this issue. We were at the White House yesterday for the signing of the proclamation declaring November 2 - 9 National Drug Abuse Education Week. The President's remarks that there is "no responsible use" of drugs by children - no hard or soft drug acceptance for children, is a far cry from the philosophy being touted by government when we first began in 1977. We're proud of that progress and we were proud to see Republicans and Democrats standing together while he signed it.

We've only begun and we welcome each of you and your spouses to join us.

THE NATIONAL FEDERATION OF PARENTS FOR DRUG-FREE YOUTH NATIONAL PARENTS' HOT LINE #800-554-KIDS.

NADAP

NATIONAL ASSOCIATION ON DRUG ABUSE PROBLEMS INC.

355 LEXINGTON AVENUE
NEW YORK, NEW YORK 10017
TELEPHONE (212) 986-1170

TESTIMONY
OF FATHER
JOHN MCVERNON
EXECUTIVE
VICE PRESIDENT
BEFORE THE HOUSE
SELECT COMMITTEE
ON NARCOTICS
NOVEMBER 2, 1983

Mr. Chairman and Honorable members of the Committee. The National Association on Drug Abuse Problems is an organization as far as we know unique in the nation.

We are a creation of the business community, our Board is comprised of corporate and union leaders and our charge is to study the interface between drugs and work and to act on behalf of the business community to lessen the harm that drugs bring to our nation.

We are engaged in a whole range of activities including educational programs which better prepare treatment counselors to serve the vocational needs of their clients, services to corporate and union troubled employee programs to enhance their capacity to help drug problemed workers and a bi-annual Scientific Conference intended to enhance the quality of drug abuse treatment by improving the data base on which programs are built.

Today we want to comment on two aspects of the Federal Strategy.

First, around the issue of employment. For recovering persons, nothing is more important to the maintenance of their good functioning, than their successful integration with conventional society. For most that means finding employment.

Contrary to some of the myths about addicted persons, most have a marketable skill and most have some work history.

Contrary to some of the myths about employers, many are willing to hire recovered drug abusers. One vice president of a national retailing firm told us that "Given our location, if we did'nt hire former drug abusers we couldn't hire anybody. We much prefer the person who has gone through a program."

In honesty, we have consistently had more job opportunities offered by employers than job-ready clients coming out of programs. Despite the horrendous economic circumstances of the past twelve months we have regularly been placing more former drug abusers, per month, than at any other period in our twelve-year history.

Even in those programs where there are well-prepared vocational staff there is so large a caseload for each counselor and there are so many clinical issues at hand that the time available to prepare each client for entry to the world of work is so brief as to be insignificant.

All of us know that addiction, like alcoholism, is a recurring phenomenon. What a tragedy it is for the person who has struggled to free themselves of the succubus of drugs to find themselves months after treatment back in the hustle for lack of a job. We need a clearer statement on the weight to be put on vocational issues. How better to judge a program than by how many of its participants are in school, in training in the service or in jobs.

There ought to be practical research on those programs that do emphasize employment and how well those participants do in their work and in their recovery.

In certain of the major metropolitan areas the federal government could encourage-even initiate-work centers with high input from loaned executives to channel the job-ready treatment successes into the mainstream of employment.

Our second point has to do with prevention. Among the many ways in which contemporary drug problems impact negatively on American business, we see the loss of time and talent on the part of working people who are disabled as workers because of the pain and anxiety they suffer as a result of drug use among their loved ones, especially the children.

We have the utmost respect for the men and women who labor in prevention programs. They have a difficult task because not everyone is agreed on what they should be preventing but everyone is sure there is a better way of doing it. Addiction is like a cave. The further you venture into the cave the longer your journey out. With this difference. The way you get out is not the way you got in. And not everybody gets out. The earlier you halt the journey, the easier the escape.

Federal strategy should encourage increased communication between prevention and treatment, between drug abuse services and the whole human service system, between human service and the whole range of community resources. The CHEMICAL PEOPLE program, funded in large part by one of NADAP's most consistent supporters Metropolitan Life Insurance, is a perfect example of that coordination.

No one segment of society is responsible for the tragic situation re: drugs in which we find ourselves. Every segment of society will have to play a role in setting the problem straight.

○